Kansas Medical Assistance Program
PO Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593

SPECIAL SEATING

PRIOR AUTHORIZATION REQUEST

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.

Provider #: _____ Provider NPI #: _____

Provider name, address & phone #:

PA does not guarantee eligibility.

If service is noncovered by KMAP, PA is void.

PA does not override Primary Care Network (PCN) referral limitation.

PA does not override program limitations.

GENERAL BENEFICIARY INFORMATION

Beneficiary Medicaid ID #	Beneficiary name (last, first, MI)	Date of birth

Diagnosis description

Seating clinic evaluation: Yes ☐ No ☐ Date: _____/_____/_____

Name of seating clinic: _____

Answer the following questions:

(1) How many hours per day is the special seating needed? _____

(2) Will special seating be used for purchase or rental wheelchair? _____

(3) If power wheelchair:
- Does beneficiary have a manual wheelchair? Yes ☐ No ☐
- Will special seating be used interchangeably between power and manual? Yes ☐ No ☐

(4) What are the plans or options for the beneficiary if special seating is not provided?

_____

_____

_____

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SPECIAL SEATING

PRIOR AUTHORIZATION REQUEST (continued)

	CODE	DESCRIPTION	MSR	REQUESTING
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				

The reimbursement approved includes all assembly of the special seating and attachment to the wheelchair.

Provider is responsible for providing the most current manufacturer suggested retail (MSR) pricing.

Date service requested: ____/____/_____

Provider signature: _____ Date: ____/____/_____

Fax completed forms to 1-800-913-2229 or 785-274-5956.
This form will be returned unprocessed if it is not completed in its entirety.
If this request is not received within 15 working days, PA will be denied.
Prior Authorization: 1-800-933-6593