Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

Traumatic Brain Injury Program Eligibility Attestation

(This form may be used in place of submittal of medical records.)

PATIENT INFORMATION		
Patient name:	Date of birth:	Social Security number:
Patient address:	Medicaid ID:	

MEDICAL PROVIDER		
Date of office visit:	Date of injury:	Was the patient under your care at the time of the injury? ☐Yes ☐No
Cause of injury: ☐ Fall (resulting in forceful blow to head) ☐ Motor vehicle accident ☐ Assault ☐ Other:		
Method used to verify patient's brain injury: ☐Review of records ☐ Patient examination/assessment ☐Other:		

ATTESTATION

I, _____, have completed a review of the patient's records and verified the assessment and attest that the person demonstrates a need for rehabilitative services as a result of a traumatic brain injury (TBI). I understand that the State program definition of a TBI is a traumatically acquired head injury caused by an external physical force, such as blunt/penetrating trauma or accelerating-decelerating forces. I attest that the person demonstrates a capacity to make rehabilitative progress in regaining or relearning functional skills needed to remain in the community.

_____ _____
Signature, credential* Date

_____
Print name, credential*

*****Must be completed by a Qualified Medical Professional, which is defined as: any individual granted the authority to make a medical diagnosis by a licensing board in the State of Kansas (such as MD, DO, PA-C, APRN, or neuropsychologist).

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