Kansas

PLEASE ATTACH THIS FORM TO
ALL CLAIMS REQUIRING
MEDICAL DOCUMENTATION.

RETURN TO:
KANSAS MEDICAID ADMINISTRATOR
P. O. BOX 3571
TOPEKA, KANSAS 66601-3571

CERTIFICATE OF MEDICAL NECESSITY

FOR OFFICE USE ONLY

60-14 (03/2013)

PATIENT NAME AND NUMBER		BILLING DATE
PROCEDURE CODE	DESCRIPTION OF ITEM/SERVICE PRESCRIBED	DATE PRESCRIBED
DIAGNOSIS		
PROGNOSIS		
REASON FOR EQUIPMENT, APPLIANCE, MEDICAL SUPPLIES, OR PROCEDURE PRESCRIBED		ESTIMATE IN MOS. THE NEED FOR EQUIPMENT

I CERTIFY THAT THE ABOVE SERVICE OR SUPPLY WAS PRESCRIBED
AS MEDICALLY NECESSARY TO ALLEVIATE OR IMPROVE THE
CONDITION OR DIAGNOSIS INDICATED ABOVE.

PROVIDER SIGNATURE	DATE	PROVIDER NAME AND NUMBER

NOTE: This form is not to be used for sterilizations or hysterectomies. File either the Sterilization Consent Form or the Hysterectomy Consent Form, whichever is appropriate.