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

MEDICARE NONASSIGNED REQUEST

NAME: _____

BENEFICIARY ID NUMBER: _____

At the time I rendered medical services to the individual named on the attached claim, I was unaware that he/she was a beneficiary of Kansas Medicaid. Therefore, I filed the Medicare portion of this claim nonassigned. I would like to accept this individual as a Medicaid patient and take assignment on this claim. I certify I have not and will not charge the patient the difference between the Medicare/Medicaid allowable and my billed charge.

_____
PROVIDER'S SIGNATURE

_____
PROVIDER NUMBER

NOTE: Attach this form to the claim and EOMB and forward to:
Office of the Fiscal Agent
P. O. Box 3571
Topeka, KS 66601-3571