

## KS KCPC Transition of Care Request

This form is for use by providers who DO NOT have access to the KCPC application. Please complete one form for each member who you are requesting services for during the transition phase of 7/1/07-10/01/07. All information must be complete on this form to process a request for authorization. Any missing or incomplete information may delay the authorization process. Please fax completed form to 785-338-9022.

### Provider Information

Provider Last Name:	Provider First Name:	Provider Tax ID:
Servicing Address:	Servicing City, State:	Servicing Zip:
Provider Phone #:	Provider Licensure Level:	Provider ID# (Value Options or KCPC):

### Member Information

Member Last Name:	Member First Name:	Member Middle Name:
Member Address:	Member City, State:	Member Zip:
Gender:	Date of Birth:	Member Social Security #
Medicaid #:	KCPC Unique ID # if known:	Yearly Household Income:
People in Household:	Member Maiden Name if applicable:	Funding Status: (Medicaid, AAPS Funded)

### Treatment Request

Level of Care of Treatment:	Admission Date:	Diagnosis:
Services Requested:	# Sessions Used to Date:	
Additional Services Requested:	# Sessions Used to Date:	
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