Kansas Department of Health and Environment
Children and Youth with Special Health Care Needs
1000 SW Jackson Suite 220 785-296-1312
Topeka KS 66612 1-800-332-6262

Submit by Email

Professional Provider Application

PROVIDER NAME (PLEASE TYPE)			SPECIALTY CLASSIFICATION	
NAME OF AUTHORIZED REPRESENTATIVE				
FEDERAL TAX ID. OR SOCIAL SECURITY NUMBER			STATE LICENSE NO. (IF APPLICABLE)	TELEPHONE NUMBER
TYPE OF PROVIDER ☐ HOSPITAL ☐ DENTIST ☐ THERAPIST ☐ PHYSICIAN(M.D/D.O) ☐ OTHER _____				
BUSINESS/AGENCY NAME/MEDICAL GROUP			NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI)	
LOCATION ADDRESS (STREET, ETC)			CITY STATE ZIP CODE	
TELEPHONE	EMAIL ADDRESS	FAX NUMBER		COUNTY
PAYMENT MAILIING ADDRESS (IF DIFFERENT FROM LOCATION ADDRESS) (STREET ETC.)			PAYMENT TELEPHONE	
CITY	STATE	ZIP CODE		COUNTY
IS THIS BUSINESS/AGENCY A MEDICAID/HEALTHWAVE PROVIDER? ☐ YES IF YES, ENTER NUMBER_____ ☐ NO				

1) By signing this agreement, the provider agrees to provide individual service or goods as authorized by KDHE/CYSHCN.
2) You and your designated staff agree to comply with the Kansas Act Against Discrimination (K.S.A. 44-1001 et seq) and the Americans with Disability Act (42 U.S.C. 1210 et seq) ADA and not discriminate against any person because of race, religion, color, sex, disability, national origin or ancestry, in the admission or access to, or treatment care provided.
3) Your signature indicates you are willing to provide medical records, if requested, to support the services/goods invoiced for payment.
4) All reasonable effort will be made to pursue third-party payments for services (private insurance, Title XIX, SCHIP and other coverage). If payment is greater than CYSHCN's allowance from another funding source, no further payment will be made.
5) The provider shall not require or request payment for authorized services from clients covered by this agreement. The provider shall have the express right to bill clients covered under this agreement for

services that are not authorized. Unauthorized services are those for which the department has not given specific prior authorization.

6) All bills for approved client services must be submitted to KDHE/CYSHCN within sixty (60) days following the date of service. All bills for approved client services must be submitted within thirty (30) days after the close of the state fiscal year, June 30 of each year.
7) Obligations under this agreement shall be suspended at such time as funds are not available to cover payment for services provided to qualified clients. However, suspension shall not eliminate coverage under this agreement for services which have been approved by KDHE/CYSHCN and which have already been furnished prior to the date of suspension.

CERTIFICATION: By signing this form you are stating that you/your staff are licensed/certified in Kansas to provide services that you have selected from the menu on the reverse side. Your signature also indicates that you agree to comply with the policies, procedures, and billing guidelines of the KDHE/CYSHCN. Failure to abide by these policies and procedures could result in the termination of your contract with KDHE/CYSHCN.		
I CERTIFGY THAT THE INFORAMTION PROVIDED IS ACCURATE AND TRUE	**SIGNATURE OF APPLICANT/ AURHTORISED PRESENTATIVE**	**DATE**

TYPES OF SERVICES YOU WILL PROVIDE TO CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Dentistry
- ☐ Endodontics
- ☐ General
- ☐ Oral Surgery
- ☐ Orthodontics
- ☐ Pedodontia
- ☐ Periodontics
- ☐ Prosthodontics

Durable Medical Equipment
- ☐ Augmentative communication device & Repair
- ☐ DME equipment & Repairs
- ☐ Hearing Aid Services & Repairs
- ☐ Orthotics
- ☐ Prosthetics
- ☐ Supplies

Emergency Transportation
- ☐ Emergency Transportation Services

Evaluation & Therapy
- ☐ Audiology
- ☐ Augmentative Communication Evaluation Team
- ☐ Cleft Lip & Palate Management Team
- ☐ Nutrition (Registered Dietitian)
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Respiratory Therapy
- ☐ Speech Language Pathology/Speech Therapy

Facility Treatment Center
- ☐ Ambulatory Surgery Center
- ☐ Emergency Care Center
- ☐ Hospital Services (Inpatient)
- ☐ Hospital Services (Outpatient)

Interpreter Services
- ☐ Bilingual (List Languages)

  _____
  _____
  _____
  _____
  _____
- ☐ Sign

Pathology
- ☐ Laboratory Services

Pharmacy
- ☐ Pharmacy Services

Physician
- ☐ Anesthesiology
- ☐ Cardiology
- ☐ Cardiology, Pediatric
- ☐ Chiropractic
- ☐ Dermatology
- ☐ Dermatology, Pediatric
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ Gastroenterology, Pediatric
- ☐ Genetic (Eval)
- ☐ Hematology
- ☐ Medicine, Internal
- ☐ Medicine, Pediatric Rehabilitation

- ☐ Medicine, Physical and Rehabilitation
- ☐ Nephrology
- ☐ Nephrology, Pediatric
- ☐ Neurology
- ☐ Neurology, Pediatric
- ☐ Ophthalmology
- ☐ Orthopedic
- ☐ Orthopedic, Pediatric
- ☐ Pathology
- ☐ Pediatrics
- ☐ Pediatrics, Developmental
- ☐ Podiatry
- ☐ Proctology
- ☐ Pulmonary
- ☐ Pulmonary, Pediatric
- ☐ Radiology
- ☐ Rheumatology
- ☐ Rheumatology, Pediatric
- ☐ Surgery, Abdominal
- ☐ Surgery, Cardiovascular
- ☐ Surgery, Colon and Rectal
- ☐ Surgery, Facial Plastic
- ☐ Surgery, Hand
- ☐ Surgery, Head and Neck
- ☐ Surgery, Maxillocranial
- ☐ Surgery, Neurosurgery
- ☐ Surgery, Orthopedic
- ☐ Surgery, Otolaryngology
- ☐ Surgery, Pediatric
- ☐ Surgery, Plastic and Reconstructive
- ☐ Surgery, Thoracic
- ☐ Surgery, Urological
- ☐ Surgery, Vascular
- ☐ Urology

Other Services

_____

_____

_____

Please Return Application To: dgibbons@kdheks.gov