Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

I, (print name clearly) ____________________________________, understand that the user ID I obtain from the Medicaid fiscal agent, Electronic Data Systems (EDS), is for the purpose of loading or approving plans of care in the electronic Prior Authorization system. This system and used ID are for the use by Home and Community Based Services (HCBS) case managers or independent living counselors, their authorized data entry persons, and Level II or Level III approval staff only.

Please complete the following information:

Name ____

SSN or Agency EIN (Mandatory) ____

Employing Agency Name: _____________________________Phone Number (___) ________

Agency Address ____

Agency Code ____

Waiver(s), circle all that apply: Autism, PD, MRDD, HI, FE, SED, Consortium

I also understand that this user ID is for my use only and the password should not be shared with other staff. Sharing the password violates the security of the used ID and is misuse. I understand that if I misuse the user ID I may lose access without notice from EDS.

If I terminate employment or affiliation with the agency I will contact EDS to inactivate this user ID.

Signed,

____

Date

____

The signature of the following authorized person must also be on this form. For the FE waiver, the Director of the Area Agency on Aging; for HI, the Director of the CIL or Home Health Agency; for the MRDD, the CDDO Executive Director; for PD, the Director of the CIL or Home Health Agency; for SED, the Community Mental Health Center Director; for the Consortium, the Manager of Crisis and Care Services.

Signed,

____

Date

____

[2]SRS Approval by: __________

____

[1]Revised 9/20/2002 EDS