Kansas
Department of Health and Environment
Division of Health Care Finance

FAX COVER SHEET

TO: State Self Insurance Fund
FAX: 785-296-6995
FROM:
PHONE:
DATE:

NUMBER OF PAGES (Including Cover sheet) ___2_____

COMMENTS: (to be completed and submitted with written restrictions immediately after each and every appointment.)

Claimants name: _____

Claimants SS# or claim #: _____

Date of Injury: _____

_____ Our agency **WILL** be able to accommodate written restrictions provided by Dr _____ beginning _____.

_____ Our agency will **NOT** be able to accommodate written restrictions provided by Dr _____ as of _____.

Follow up appointment date/time _____ with Dr _____.

CONFIDENTIAL

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www.kdheks.gov/hcf/

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Benefits and Plan Purchasing:
Phone: 785-368-6361
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State Self Insurance Fund:
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