The Center
For COUNSELING & CONSULTATION
A Licensed Community Mental Health Center

5815 Broadway • Great Bend, KS 67530
800-875-2544 • 620-792-2544 • 620-792-7052 (fax)

MEDICAID/MEDIKAN CLIENT NOTICE OF PAYMENT RESPONSIBILITY

CLIENT INFORMATION		
Last Name:	First Name:	Client ID:

MEDICAID AND MEDIKAN CLIENT - PLEASE BE ADVISED THAT YOU WILL BE RESPONSIBLE FOR PAYMENTS OF SERVICES UNDER THE FOLLOWING CONDITIONS:

1. Client not eligible when services were provided.
2. Client did not inform the provider of eligibility timely.
3. Non-covered services.
4. Client is a Qmb and service is covered by Medicare.
5. When other insurance does not reimburse the provider because there was lack of authorization or information.

_____ **X** _____

Date — Signature of Client/Responsible Party/Guardian

_____ **X** _____

Date — Witness