



**ELIZABETH LAYTON
CENTER**

For Hope and Guidance

**ADVANCED BENEFICIARY NOTICE
MEDICAID CLIENTS**

Beneficiary Name: _____

Medicaid #: _____

This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the provider and payment is not made by Kansas Medical Assistance Program KMAP, you may be held responsible for the charges if your services are not covered by KMAP.

Signature of Patient or Patient Representative

Date