



KERN HEALTH SYSTEMS

Medication Authorization Request

Pharmacy Department
9700 Stockdale Hwy
Bakersfield, Ca. 93311
Phone (661) 664-5101
Fax (661) 664-5191

KHS Date Rec'd Stamp

Authorization#

Member Information: (Complete In Full)

Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____ City: _____ Zip: _____

CIN#: _____ Phone#: _____

Pharmacy Information: (Complete In Full)

Name: _____ NPI#: _____ Phone: _____ Fax: _____

Address: _____ City: _____ Zip: _____

Requested information: (Complete In Full)

Drug & Strength (One per Form): _____ NDC#: _____

Quantity _____ Sig: _____ # of Refills: _____ Diagnosis: _____

Medical Justification: _____ Date of Service: _____

Prescriber Information: (Complete In Full)

Name: _____ NPI#: _____ Phone: _____ Fax: _____

Address: _____ City: _____ Zip: _____

For KHS Use Only

Approved Modified _____ Comments/Reason: _____

Denied Deferred _____

Duplicate Cancel _____

Initials: _____ Date: _____ Approved From: _____ Thru _____

AUTHORIZATION CONTINGENT UPON ELIGIBILITY ON DATE OF SERVICE

To the best of my knowledge, the above information is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Signature of Physician/Provider

Title

Date

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