



Kern Family Health Care

The Friendly Face
Of Kern Health Systems

Referral/Prior-Authorization Form
Phone: 661/664-5083
Fax: 661/664-5190

Please Check Type: Routine Urgent/Expedited
Please Check Product: KFHC Medi-Cal KFHC Healthy Families GHP

PLEASE PRINT Member Information: (Complete in full)

Patient Name:		Alternate Contact Information:		
Address	City	State	Zip	Daytime Phone
KFHC Member ID#	DOB:	Age:	CCS Eligible Condition: YES NO	
Alternate ID#		CCS Open Case #:		

PLEASE PRINT Facility / Provider Information: (Complete in full)

Requesting Provider:		Phone:	Fax:
Address:			
Provider Signature:		Date:	
Requested Service(s):		ICD9 Code(s) _____	
		CPT Code(s) _____	
<input type="checkbox"/> Patient Request <input type="checkbox"/> Allergy <input type="checkbox"/> Endocrine <input type="checkbox"/> Hem/Onc <input type="checkbox"/> Neurology <input type="checkbox"/> Cardiology <input type="checkbox"/> ENT <input type="checkbox"/> Home Health <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Dermatology <input type="checkbox"/> GE/GI <input type="checkbox"/> Mental Health <input type="checkbox"/> OB/GYN <input type="checkbox"/> DMME <input type="checkbox"/> General Surgery <input type="checkbox"/> Nephrology <input type="checkbox"/> Ophthalmology		Facility _____ <input type="checkbox"/> Orthopedics <input type="checkbox"/> Podiatry <input type="checkbox"/> Urology <input type="checkbox"/> Pain Mgmt <input type="checkbox"/> Radiology <input type="checkbox"/> Pharmacy <input type="checkbox"/> Rheumatology <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Pulmonology	
Requested Provider:		Phone:	Fax:
Address:			

INFORMATION BELOW MUST BE COMPLETED TO PROCESS SERVICE REQUEST

Diagnosis / Clinical Problem:	KFHC Date Rec'd Stamp
Clinical History / Date of Onset:	

To facilitate processing of request, please attach clinical documentation including progress notes, reports, labs, imaging, etc. (Total additional pages _____)

For Kern Family Health Care Use ONLY:

Approved Denied Modified Withdrawn Delayed Duplicate Request Disenrolled

Auth # _____

Commentary/UM Criteria Not Met: _____

Reviewer Signature _____ Date _____

PCP _____

AUTHORIZATION CONTINGENT UPON ELIGIBILITY ON DATE OF SERVICE Eligibility Date _____

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