



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

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):	ICD10 Code(s) _____	
	CPT Code(s) _____	
<input type="checkbox"/> Patient Request	Facility _____	
<input type="checkbox"/> Allergy	<input type="checkbox"/> Endocrine	<input type="checkbox"/> Hem/Onc
<input type="checkbox"/> Cardiology	<input type="checkbox"/> ENT	<input type="checkbox"/> Home Health
<input type="checkbox"/> Dermatology	<input type="checkbox"/> GE/GI	<input type="checkbox"/> Mental Health
<input type="checkbox"/> DMED	<input type="checkbox"/> General Surgery	<input type="checkbox"/> Nephrology
<input type="checkbox"/> Neurology	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> OB/GYN
<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Pain Mgmt
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Podiatry	<input type="checkbox"/> Radiology
<input type="checkbox"/> Pulmonology	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> Urology		
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:	
<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Modified <input type="checkbox"/> Withdrawn <input type="checkbox"/> Delayed <input type="checkbox"/> Duplicate Request <input type="checkbox"/> Disenrolled	Auth # _____
<input type="checkbox"/> Commentary/UM Criteria Not Met: _____	
Reviewer Signature _____	Date _____
	PCP _____

AUTHORIZATION CONTINGENT UPON ELIGIBILITY ON DATE OF SERVICE Eligibility Date _____

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