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) _____

Facility _____

❑Patient Request

❑Allergy	❑Endocrine	❑Hem/Onc	❑Neurology	❑ Orthopedics	❑Podiatry	❑Urology
❑Cardiology	❑ENT	❑Home Health	❑Neurosurgery	❑Pain Mgmt	❑Radiology	
❑Dermatology	❑GE/GI	❑Mental Health	❑OB/GYN	❑Pharmacy	❑Rheumatology	
❑DME	❑General Surgery	❑Nephrology	❑Ophthalmology	❑ Physical Therapy	❑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❑Approved ❑Denied ❑Modified ❑Withdrawn ❑Delayed ❑Duplicate Request ❑Disenrolled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 _____