Kern Family Health Care™

# PROVIDER AUTHORIZATION APPEAL RESOLUTION REQUEST

**INSTRUCTIONS**

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF APPEAL and EXPECTED OUTCOME.
- Provide additional information to support the description of the appeal.
- Fax the form along with any attachments to: (661) 664-4303
- Or mail the completed form to: Kern Family Health Care – Grievance and Appeals
  2900 Buck Owens Boulevard
  Bakersfield, CA 93308

| | |
|---|---|
| ***PROVIDER NAME:** | ***PROVIDER ID NUMBER:** |
| ***PROVIDER ADDRESS:** | |
| ***PROVIDER PHONE NUMBER:** | |

| | | |
|---|---|---|
| *** MEMBER NAME:** | | ***DATE OF BIRTH:** |
| *** KFHC ID Number:** | **MEMBER ADDRESS/PHONE NUMBER** | ***ORIGINAL AUTH NUMBER:** (Please complete a separate form for each appeal) |

*** DESCRIPTION OF APPEAL (**must include a clear explanation of the basis upon which you believe KHS's action is incorrect)**:**

**EXPECTED OUTCOME:**

_____ _____ (  )_____
***Provider Contact Name (please print)** **Title** ***Phone Number**

_____ _____ (  )_____
***Signature** ***Date** ***Fax Number**

***All provider appeals submitted on a member's behalf must include the member's, their parent's (if a minor) or other authorized representative's signature and date indicating provider has their consent to file this appeal.**

**Member, Parent or Authorized Representative's Signature:_____ Date:_____**

**Kern Family Health Care received this appeal on _____. If you have a question regarding this appeal, please call the KFHC Member Services Department at 1-800-391-2000 and ask to speak with a Grievance Coordinator.**

_____
**Acknowledgement of Receipt (signature)**