Kern Family Health Care
Medicare (D-SNP)

Phone: 1-866-661-3767 / 661-716-5342
Fax: 1-661-605-0315

Prior Authorization Form

Please Check Type: ☐ Expedited / Urgent ☐ Standard / Routine **Line of Business:** ☐ Medicare ☐ Medi-Cal ☐ D-SNP

Name of Person Submitting Authorization: **Date of Submission**:

Member Information: (Must complete in full)

Patient Name: **DOB:** **Age:**

Address: **Daytime Phone:**

Member ID# **Alternate ID/Other Coverage:**

Requesting Provider Information: (Must complete in full)

Requesting Provider: **Address:**

Phone: **Fax:**

Provider NPI # **Tax ID #**

Provider Signature: **Date:**

Requested Service(s) (Must complete in full)

ICD10 Code(s): **CPT Code(s)**

Requested Specialty: **Place of Service:** ☐**Office** ☐ **Outpatient** ☐ **Inpatient**

Requested Unit(s) ☐ **Ambulatory Surgery Center** ☐ **Other**

Clinical History / Date of Onset:

Requested / Servicing Provider and Facility Information: (Must complete in full)

Requested Provider: **Address:**

Requested Provider Phone: **Fax:**

Requested Provider NPI # **Tax ID #**

Requested Facility: **Address:**

Facility Phone: **Fax:**

Facility NPI#: **Tax ID #:**

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