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)