Kern Family Health Care
Medicare (D-SNP)

MEDICARE D-SNP SELF-REFERRAL FORM

Patient Information:

Full Name: _____

Date of Birth: _____

Medicare D-SNP Member ID: _____

Phone Number: _____

Email Address: _____

Home Address: _____

Mailing Address (If different from home): _____

Referral Details (Reason for Request of Services Under Medicare D-SNP):

Reason for Self-Referral:_____

Provider/Service Requested:

Specialty or Department: _____

Requested Provider: _____

Requested Provider Phone Number: _____

Requested Provider Address: _____

Additional Information:_____

_____

_____

Patient Authorization I hereby certify that the information provided is accurate to the best of my knowledge and authorize the healthcare provider or organization to review this self-referral.

Member or Authorized Representative:

Signature: _____

Date: _____

If signed by an authorized representative:

Name: _____

Relationship: _____

Member Services Department
Kern Family Health Care
2900 Buck Owens Boulevard
Bakersfield, CA 93308

If you have questions or need help filling out this form, please call our Member Services Department at **866-661-3767 / 661-716-5342**

We will review your request and send you a letter that explains our decision.

For Office Use Only –

Date Received: _____

Reviewed By: _____

Referral Status: _____