



# Bed Hold Authorization Request Form

Utilization Management

Phone: 1-408-874-1821

Fax: 1-408-874-1957

Email: [UMHelpDesk@scfhp.com](mailto:UMHelpDesk@scfhp.com)

Within 24 hours of return from bed hold, please complete this form and fax it to Santa Clara Family Health Plan Utilization Management (UM) Department. If you have any questions, please contact the UM Department or refer to the [Bed Hold Authorization Request Form FAQs](#).

Today's date: \_\_\_\_\_

Member name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Member ID: \_\_\_\_\_

Line of business:  Cal MediConnect  Medi-Cal

Start date of bed hold: \_\_\_\_\_ Return date: \_\_\_\_\_

Transferred to (hospital name): \_\_\_\_\_

Reason for transfer:

Name of facility: \_\_\_\_\_

Your name: \_\_\_\_\_ Phone: \_\_\_\_\_

NPI: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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