



# 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:  DualConnect  Medi-Cal

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

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

Reason for transfer:

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

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

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

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

Confidentiality Notice: This electronic fax transmission (including any documents, files or previous email messages attached to it) may contain confidential information that is intended for a specific individual and purpose and that is privileged or otherwise protected by law. If you are not the intended recipient, or a person responsible for delivering it to the intended recipient, please delete this fax and notify SCFHP UM of the error. Any disclosure, copying or distribution of this message, or taking of any action based on it, is strictly prohibited.