Bed Hold Authorization Request Form

Utilization Management
Phone: **1-408-874-1821**
Fax: **1-408-874-1957**
Email: 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: _____