



# PROVIDER AUTHORIZATION DISPUTE RESOLUTION REQUEST

## INSTRUCTIONS

- Please complete the below form. Fields with an asterisk ( \* ) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
- Mail the completed form to: Utilization Management Department – Kern Family Health Care  
9700 Stockdale Hwy  
Bakersfield, CA 93311

|                          |  |
|--------------------------|--|
| <b>*PROVIDER NAME:</b>   | <b>*PROVIDER TAX ID # / Medicare ID #:</b> |
| <b>PROVIDER ADDRESS:</b> |  |

**PROVIDER TYPE**     MD     Mental Health     Hospital     ASC     SNF     DME     Rehab  
 Home Health     Ambulance     Other \_\_\_\_\_  
(please specify type of "other")

**\* AUTHORIZATION INFORMATION**     Single     Multiple "LIKE" Authorizations (complete attached spreadsheet)  
*Number of authorizations:* \_\_\_\_\_

|                                 |                                |   |
|---------------------------------|--------------------------------|---|
| <b>* Patient Name:</b>          |                                | <b>Date of Birth:</b>   |
| <b>* Health Plan ID Number:</b> | <b>Patient Account Number:</b> | <b>*Original Authorization Number:</b> (If multiple claims, use attached spreadsheet) |

**DISPUTE TYPE:** First Level \_\_\_\_\_ Second Level \_\_\_\_\_

**\* DESCRIPTION OF DISPUTE** (must include a clear explanation of the basis upon which you believe KHS' action is incorrect):

**EXPECTED OUTCOME:**

|                                     |              |                      |
|-------------------------------------|--------------|----------------------|
| _____                               | _____        | (    ) _____         |
| <b>*Contact Name (please print)</b> | <b>Title</b> | <b>*Phone Number</b> |
| _____                               | _____        | (    ) _____         |
| <b>Signature</b>                    | <b>Date</b>  | <b>*Fax Number</b>   |

Kern Family Health Care received this dispute on \_\_\_\_\_. If you have a question regarding this dispute, please call the Utilization Management Department at 1 800 391-2000.

\_\_\_\_\_ (signature)  
**Acknowledgement of Receipt**

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(For use with multiple "LIKE" authorizations)

| Number | * Patient Name |       | Date of Birth | * Health Plan ID Number | Original Authorization Number |
|--------|----------------|-------|---------------|-------------------------|-------------------------------|
|        | Last           | First |               |                         |                               |
| 1      |                |       |               |                         |                               |
| 2      |                |       |               |                         |                               |
| 3      |                |       |               |                         |                               |
| 4      |                |       |               |                         |                               |
| 5      |                |       |               |                         |                               |
| 6      |                |       |               |                         |                               |
| 7      |                |       |               |                         |                               |
| 8      |                |       |               |                         |                               |
| 9      |                |       |               |                         |                               |
| 10     |                |       |               |                         |                               |
| 11     |                |       |               |                         |                               |
| 12     |                |       |               |                         |                               |
| 13     |                |       |               |                         |                               |
| 14     |                |       |               |                         |                               |
| 15     |                |       |               |                         |                               |