KERN HEALTH SYSTEMS

Medication Authorization Request

Pharmacy Department
9700 Stockdale Hwy
Bakersfield, Ca. 93311
Phone (661) 664-5101
Fax (661) 664-5191

KHS Date Rec'd Stamp

Authorization#

Member Information: (Complete In Full)

Patient Name: ____________________ DOB: ____________ Age: ________ Sex: ________

Address: ____________________ City: ____________________ Zip: ____________

CIN#: ____________________ Phone#: ____________________

Pharmacy Information: (Complete In Full)

Pharmacy Name: ____________________ NPI/NCPDP: ____________________

Address: ____________________ Phone#: ____________________ Fax#: ____________

Requested information: (Complete In Full)

Drug & Strength(One per Form): ____________________ NDC#: ____________________

Quantity ________ Sig: ____________________ # of Refills: ________ Diagnosis: ____________________

Medical Justification: Date of Service: ____________________

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____

____

Prescriber Information: (Complete In Full)

Prescriber Name: ____________________ Address: ____________________

City: ____________________ Zip: ________ Phone: ____________ Fax: ____________

For KHS Use Only

___Approved ___Modified Comments/Reason: ____________________

___Denied ___Deferred ____________________

___Duplicate ___Cancel ____________________

Initials: ________ Date: ____________ Approved From: ____________ Thru ____________

AUTHORIZATION CONTINGENT UPON ELIGIBILITY ON DATE OF SERVICE

To the best of my knowledge, the above information is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

____________________ ____________ ____________

Signature of Physician/Provider Title Date

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