



# PROVIDER *bulletin*

August 31, 2010

Dear Provider:

The following changes will go into effect September 1, 2010. Please take a moment to familiarize yourself and staff to the amendments.

Kern Family Health Care is in the process of preparing for paperless TAR/PA submissions. To achieve that, the request forms must be uniform. Please use the following form. Discard any other forms you may have. It is imperative that the forms are filled out completely, such as the NPI #, accurately, diagnosis and place of service for example, and clearly, as in legibly. The form is also available at the website [kernfamilyhealthcare.com](http://kernfamilyhealthcare.com) for downloading purposes.

Thank you. See attached.

Sincerely,

Bruce Wearda, R.Ph.  
Corporate Pharmacist





# 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)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

CIN#: \_\_\_\_\_ Phone#: \_\_\_\_\_

### Pharmacy Information: (Complete In Full)

Name: \_\_\_\_\_ NPI#: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

### Requested information: (Complete In Full)

Drug & Strength (One per Form): \_\_\_\_\_ NDC#: \_\_\_\_\_

Quantity \_\_\_\_\_ Sig: \_\_\_\_\_ # of Refills: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Medical Justification: \_\_\_\_\_ Date of Service: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Prescriber Information: (Complete In Full)

Name: \_\_\_\_\_ NPI#: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

### 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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