

## MEDICARE D-SNP SELF-REFERRAL FORM

**Patient Information:**

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medicare D-SNP Member ID: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Mailing Address (If different from home): \_\_\_\_\_

**Referral Details (Reason for Request of Services Under Medicare D-SNP):**

Reason for Self-Referral: \_\_\_\_\_

**Provider/Service Requested:**

Specialty or Department: \_\_\_\_\_

Requested Provider: \_\_\_\_\_

Requested Provider Phone Number: \_\_\_\_\_

Requested Provider Address: \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Patient Authorization** I hereby certify that the information provided is accurate to the best of my knowledge and authorize the healthcare provider or organization to review this self-referral.

**Member or Authorized Representative:**

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

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

**If signed by an authorized representative:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Member Services Department  
Kern Family Health Care  
2900 Buck Owens Boulevard  
Bakersfield, CA 93308**

If you have questions or need help filling out this form, please call our Member Services Department at  
**866-661-3767 / 661-716-5342**

We will review your request and send you a letter that explains our decision.

For Office Use Only –

**Date Received:** \_\_\_\_\_

**Reviewed By:** \_\_\_\_\_

**Referral Status:** \_\_\_\_\_

[Type here]