



Bed Hold Authorization Request Form

Please return the completed form by fax to Santa Clara Family Health Plan Utilization Management (UM) Department at **1-408-874-1957** within 24 hours of return from bed hold. If you have any questions, please call the UM Department at **1-408-874-1821**.

Today's Date: _____

Member Name: _____ Date of Birth: _____

Member ID: _____

Plan: Cal MediConnect Medi-Cal

Start Date of Bed Hold: _____ Return Date: _____

Transferred to (Hospital Name): _____

Reason for Transfer:

Facility: _____

Signature: _____

Name: _____ Phone: _____

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