



FLORIDA HEALTH CARE PLANS
P.O. BOX 9910
DAYTONA BEACH, FL 32120
FHCP REFERRALS DEPT - 386-238-3230
REFERRAL FAX - 386-238-3253
FHCP 1-800-352-9824

AUTH #: _____

PRECERTIFICATION FORM

REQUEST FOR PRECERTIFICATION OF ELECTIVE PROCEDURES IS **REQUIRED 5 BUSINESS DAYS PRIOR TO THE DATE OF SERVICE.** NOTIFICATION OF ALL EMERGENCY ROOM ADMITS IS REQUIRED WITHIN 24-48 HRS.

DATE: _____
 REQUESTING PROVIDER: _____ TYPE OF REFERRAL: _____
 CONTACT/CALLER NAME: _____ ROUTINE URGENT
 PHONE NUMBER: _____ EXT: _____

Patient Name: _____ S.S.#: _____
 Medical Record #: _____ Date of Birth: _____

A. Surgical Procedure: _____ CPT Code: _____
 Surgical Procedure Date: _____ Surgeon: _____ Facility: _____
 DX: _____ ICD-9 Code: _____
 Inpatient Outpatient 23 Hour OBS Admit Date _____ Expected Length of Stay _____
 Pre-Op Testing Date: _____ Physicians Pre-op Visit Date: _____

B. Specialty or Test Requested: _____
 Initial evaluation Follow up With Contrast Without Contrast With & Without Contrast
 Appt Date: _____ Place of Service: _____
 DX: _____ ICD-9 Code: _____

PLEASE SEND ALL PERTINENT CLINICAL INFORMATION TO FHCP. THIS MAY INCLUDE LAB REPORTS, RADIOLOGY REPORTS, PATHOLOGY REPORTS, OTHER DIAGNOSTICS, H&P, AND/OR PHYSICIAN NOTES.

****This section is only for those services that require authorization. This form is intended to represent the Providers order as well as the services that have been approved by FHCP. Payment will not be authorized for services beyond those indicated below. ****

Approved by Florida Health Care Plans for: _____

Signature: _____ Date: _____