Florida Health Care Plans®

An Independent Licensee of the Blue Cross and Blue Shield Association

Florida Health Care Plans
Community Resource Program Referral

Name: _____ **Referral Date:** _____

FHCP Medical Record #: _____ **PCP:** _____

Address: _____
Street Apt. #

_____
City State Zip

DOB: _____ **Home Number:** _____ **Cell Number:** _____

Reason for Referral

- ☐ Information Only
- ☐ Auxiliary Needs
- ☐ Nursing Home/ACLF Placement
- ☐ Copayment _____
- ☐ At Risk _____
- ☐ Other _____

Priority Status

- ☐ Within 24 hours
- ☐ Within 5 Working Days
- ☐ Within 10 Working Days
- ☐ Other _____

Additional Information:

_____

_____

REFERRAL SOURCE
(Please check one and indicate name)

- ☐ Medical Doctor _____
- ☐ Member Services _____
- ☐ Home Health _____
- ☐ Nursing Home _____
- ☐ Case Management _____
- ☐ Other _____

Completed by: _____ **Date:** _____

Send to:

Case Management Coordination of Care
1510 Ridgewood Avenue,
Holly Hill, Fl 32117
Phone #: 386-238-3284
Toll Free: 855-205-7293
Fax: 386-238-3271
cmanagement@fhcp.com