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| **FHCP BCBS solid w tag** | **FLORIDA HEALTH CARE PLANS**  **P.O. BOX 10348**  **DAYTONA BEACH, FL 32120-0348**  **CENTRALS REFERRALS DEPARTMENT** | **AUTH #:** |
| **FAX – 386-238-3253 / 855-442-8398 PHONE – 386-238-3215 / 800-729-8349** | |

**PRIOR AUTHORIZATION FORM**

THIS FORM IS INTENDED TO REPRESENT THE PROVIDER’S ORDER FOR SERVICES OR SUPPLIES

**PLEASE FAX ALL PERTINENT CLINICAL INFORMATION TO FHCP AT THE NUMBER LISTED ABOVE. THIS MAY INCLUDE LABS, RADIOLOGY, PATHOLOGY REPORTS & OTHER DIAGNOSTIC STUDIES INCLUDING H&P AND/OR PROVIDER NOTES.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| TAX ID #: |  | | | | |
| DATE: |  | | | Is this the result of an auto or work related accident? | | | | | | | Yes  No |
| REQUESTING PROVIDER NAME: | | |  | | | | | | | TYPE OF REFERRAL:  ROUTINE  URGENT  (call if urgent) | |
| CONTACT NAME: | |  | | | | | | | |
| PHONE NUMBER: | |  | | | EXT: |  | | FAX: |  | | |

**BD21448_**

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| --- | --- | --- | --- |
| Patient Name: |  | Date of Birth: |  |

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| --- | --- | --- | --- |
| FHCP Medical Record #: |  | Patient Phone #(s): |  |

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| --- | --- | --- | --- |
| **A.** Surgical Procedure: |  | CPT Code: |  |

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| --- | --- | --- | --- |
| Diagnosis: |  | ICD-10 Code: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Surgical Procedure Date: |  | Surgeon: |  |

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| --- | --- |
| Facility Name: |  |
| Address: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Inpatient  Outpatient  23 Hour OBS \* | | | Admit Date | |  | Expected Length of Stay | |  |
|  | | \*Documentation is required to support 23 Hour OBS status | | | | | | |
| Pre-Op Testing Date: |  | | | Physicians Pre-op Visit Date: | | |  | |

**BD21448_**

|  |  |
| --- | --- |
| **B. OFFICE VISIT / TEST REQUESTED: (Name Provider or Test)** |  |

Test Test Test With &

Initial evaluation  Follow upWith Contrast  Without Contrast  Without Contrast

|  |  |  |  |
| --- | --- | --- | --- |
| Appt Date: |  | Testing Facility Name: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| DX: |  | ICD-10 Code: |  |

**BD21448_**

**\*\*\*\*** THIS SECTION FOR INTERNAL USE ONLY\*\*\*\* Payment will not be authorized for services beyond those indicated below. **\*\*\*\***

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| --- | --- |
| Approved by Florida Health Care Plans for: |  |

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