**FLORIDA HEALTH CARE PLANS REFERRAL FORM**

**Phone: 386-238-3230 Fax: 386-238-3253**

 **800-352-9824 855-442-8398**

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| --- | --- | --- | --- |
| Date: |       | Auth #: |       |
|  |
| **A. Member Name:** |       | Referring Provider Name: |       |
| MRN: |       | Date of Birth: |       | Contact/Caller Name: |       |
| Home Tel: |       | Work Tel: |       | Referring Provider Phone #: |       |
| Cell #: |       | Referring Provider FHCP #: |       |
| Subscriber #: |       | **Provider Signature:** |  |
| Parent / Guardian Name: |       | [ ]  Referral at Patient Request Only |
|  |
| **B. REFERRAL STATUS:** [ ]  Routine [ ]  Urgent |  Is this the result of an auto or work accident? [ ]  Yes [ ]  No |
|  **\*\*\* For urgent cases requiring prior authorization, the provider office must call** **Central Referrals Department at the number listed above. \*\*\*** |
| *Please refer to your Provider Referral Guide for assistance in completing all referrals.* |

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| **C. REFERRAL IS FOR:** |       |
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| **D. DIAGNOSIS CODE** |        | [ ]  Eval [ ]  Follow Up [ ]  2nd Opinion  |

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| **E. REASON FOR REFERRAL – TO BE COMPLETED BY CLINICIAN** *(Attach all Supporting Documentation)* |
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| **F. *THIS SECTION IS ONLY FOR THOSE SERVICES THAT REQUIRE PRE-AUTHORIZATION*** |
|  **This Form is intended to represent the Provider’s order as well as the Services that have been approved by FHCP. Payment will not be**  **authorized for services beyond those as indicated below. Authorization for additional services must be coordinated through the Member’s**  **PCP or the Referring Provider.** |
| [ ]  APPROVED BY FLORIDA HEALTH CARE PLANS FOR: |       |
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|       |
|       |
| Signature: |       | Date: |       |

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| **G. Appointment with:** |       | Date: |       | Time: |       |
|  Notes: |       |
|  |       |
|  Confirmed with: |       | By: |       | On: |       |
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