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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: |       |

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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: |       |

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

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| Facility Name: |       |
|  Address: |       |

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| [ ]  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: |       |

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

 Test Test Test With &

**[ ]** Initial evaluation [ ]  Follow up**[ ]** With Contrast [ ]  Without Contrast [ ]  Without Contrast

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

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

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**\*\*\*\*** 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_