**FLORIDA HEALTH CARE PLANS REFERRAL FORM**

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

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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**  **the Central Referral Department at the number listed above. \*\*\***  **Urgent = Serious jeopardy to life, health, maximum function** | | | | | | | | | | | | | | | | | | |
| *Please refer to your Provider Referral Guide for assistance in completing all referrals.* | | | | | | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **C. REFERRAL IS FOR:** |  |
|  | |
|  | |
|  | |

|  |  |  |
| --- | --- | --- |
| **D. DIAGNOSIS CODE** |  | Eval  Follow Up  2nd Opinion |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **E. REASON FOR REFERRAL – TO BE COMPLETED BY CLINICIAN** *(Attach all Supporting Documentation)* | | | | |
|  | | | | |
|  | | | | |
|  | | | | |
|  | | | | |
| **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: | |  | | |
|  | | | | |
|  | | | | |
|  | | | | |
| Signature: |  | | Date: |  |

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

10762\_ALL 0921R1 Rev. 08/20/21