**FLORIDA HEALTH CARE PLANS**

**SURGICAL & SPECIAL PROCEDURE FORM**

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

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

**Section 1 (Please complete all areas)**

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Auth #: |  |

|  |  |
| --- | --- |
| Is this a result of an auto or work related accident? | Yes  No |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient Name: |  | Medical Record #: |  | S.S. #: |  |

|  |  |
| --- | --- |
| Address: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Birth: |  | Phone/Home: |  | Work: |  | Cell: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| In Case of Emergency Notify: |  | Telephone: |  | Relationship: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Care Physician:** |  | **Surgeon:** |  |

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

|  |  |
| --- | --- |
| **CPT Code:** |  |

(Circle One) Routine Urgent **\*\* If your request is URGENT (Serious jeopardy to life, health, maximum function), you must CALL the Central Referral Department prior to submitting your request.**

|  |
| --- |
| (Circle One) Inpatient Outpatient \* 23 Hour Observation \* Documentation is required to support 23 hr obs status |

|  |  |
| --- | --- |
| Facility: |  |

|  |  |
| --- | --- |
| Comments – (Relating to actual surgery, if any): |  |

|  |  |
| --- | --- |
| **Surgical/Special Procedure:** |  |

|  |
| --- |
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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Procedure: |  | Time: |  | Admission Date (if inpatient): |  |

|  |  |
| --- | --- |
| Pre-Op Joint Replacement Class: Attendance Date: |  |

**Section 2 (This section is for FHCP internal use only):**

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.

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| Approved / Disapproved Date: |  | By: |  |

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