Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

FLORIDA HEALTH CARE PLANS
P.O. BOX 9910
DAYTONA BEACH, FL 32120-0348
CENTRALS REFERRALS DEPARTMENT
FAX – 386-238-3253 / 855-442-8398 PHONE – 386-238-3230 / 800-352-9824

AUTH #: _____

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

CONTACT NAME: _____

PHONE NUMBER: _____ EXT: _____ FAX: _____

If your request is URGENT you must CALL the Central Referral Department prior to submitting your request. FHCP HAS THE RIGHT TO RECLASSIFY THIS REQUEST TO ROUTINE IF THE DEFINITION OF URGENT IS NOT MET. URGENT IS SERIOUS JEOPARDY TO LIFE, HEALTH, MAXIMUM FUNCTION.

Patient Name: _____ Date of Birth: _____

FHCP Medical Record #: _____ Patient Phone #(s): _____

A. Surgical Procedure: _____

_____

Diagnosis: _____ ICD-10 Code: _____

Surgical Procedure Date: _____ CPT Code: _____ Surgeon: _____

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: _____

B. Test/Other Services Requested: (Name of Provider or Test): _____

_____

_____ ☐**Initial Eval** _____ ☐**Follow-up** _____

Appt Date: _____ Testing Facility Name: _____

DX: _____ ICD-10 Code: _____