



**Florida
Health Care
Plans**



FLORIDA HEALTH CARE PLANS

P.O. BOX 10348

DAYTONA BEACH, FL 32120-0348

CENTRALS REFERRALS DEPARTMENT

FAX – 386-238-3253 / 855-442-8398

AUTH #: _

PHONE – 386-238-3215 / 800-729-8349

An Independent Licensee of the Blue Cross and Blue Shield Association

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: _____

Patient Name: _____ Date of Birth: _____

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

A. Surgical Procedure: _____ CPT Code: _____

Diagnosis: _____ ICD-10 Code: _____

Surgical Procedure Date: _____ 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. OFFICE VISIT / TEST REQUESTED: (Name Provider or Test)

Initial evaluation Follow up Test With Contrast Test Without Contrast Test With & Without Contrast

Appt Date: _____ Testing Facility Name: _____

DX: _____ ICD-10 Code: _____

**** THIS SECTION FOR INTERNAL USE ONLY**** Payment will not be authorized for services beyond those indicated below. ****

Approved by Florida Health Care Plans for: _____

Signature: _____ Date: _____