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: _____

MRN: _____ Date of Birth: _____

Home Tel: Work Tel: _____

Cell #:

_____

Subscriber #:

Parent / Guardian Name:

Referring Provider Name: _____

Contact/Caller Name: _____

Referring Provider Phone #: _____

Referring Provider Fax #:

Referring Provider FHCP #:

Provider Signature: _____

☐ 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.
FHCP HAS THE RIGHT TO RECLASSIFY THIS REQUEST TO ROUTINE IF THE DEFINITION OF URGENT IS NOT MET.

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.

Please refer to your Provider Referral Guide for assistance in completing all referrals .

C. REFERRAL IS FOR: _____

D. DIAGNOSIS CODE: _____

_____

_____

☐ **Eval** ☐ **Follow-Up** ☐ **Second Opinion**