FLORIDA HEALTH CARE PLANS
SURGICAL & SPECIAL PROCEDURE FORM

Phone: 386-238-3230 Fax: 386-238-3253
800-352-9824 855-442-8398

Please complete all areas and include clinical notes with this request

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:** _____

Contact Name @ Surgeon's office: **Phone number for Contact:**

Fax number for Contact:

Diagnosis: _____ **ICD-10 Code:** _____

CPT Code: _____

Routine ☐ Urgent ☐ ** **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.**

(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: _____

_____

_____

Date of Procedure: _____ Time: _____ Admission Date (if inpatient): _____

Pre-Op Joint Replacement Class: Attendance Date: _____