FLORIDA HEALTH CARE PLANS
P.O. BOX 9910
DAYTONA BEACH, FL 32120-0348
CENTRALS REFERRALS DEPARTMENT
FAX – 386-238-3253 / 855-442-8398 PHONE – 386-238-3215 / 800-729-8349
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
Urgent is serious jeopardy to life, health, maximum function
(Must 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: ______________________

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Signature: ______________________ Date: ______________________