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 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

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

C. REFERRAL IS FOR: ____________________

D. DIAGNOSIS CODE ____________________ ☐ Eval ☐ Follow Up ☐ 2nd Opinion

E. REASON FOR REFERRAL – TO BE COMPLETED BY CLINICIAN *(Attach all Supporting Documentation)*

F. ***THIS SECTION IS ONLY FOR THOSE SERVICES THAT REQUIRE PRE-AUTHORIZATION***

This Form is intended to represent the Provider's order as well as the Services that have been approved by FHCP. Payment will not be authorized for services beyond those as indicated below. Authorization for additional services must be coordinated through the Member's PCP or the Referring Provider.

☐ APPROVED BY FLORIDA HEALTH CARE PLANS FOR: ____________________

Signature: Date:

G. Appointment with: ____________________ Date: __________ Time: __________

Notes: ____________________

Confirmed with: __________ By: __________ On: __________