FLORIDA HEALTH CARE PLANS
SURGICAL & SPECIAL PROCEDURE FORM

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

Section 1 (Please complete all areas)

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:**

Diagnosis: ______________________ **ICD-10 Code:** ______________________

CPT Code: ____

(Circle One) Routine Urgent ** **If your request is URGENT (Serious jeopardy to life, health, maximum function), you must CALL the Central Referral Department prior to submitting your request.**

(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: ______________________

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

Pre-Op Joint Replacement Class: Attendance Date: ______________________

Section 2 (This section is for FHCP internal use only):
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.

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Approved / Disapproved Date: ____________ By: ______________________