Florida Health Care Plans®
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FLORIDA HEALTH CARE PLANS
P.O. BOX 9910
DAYTONA BEACH, FL 32120-0348
UTILIZATION REVIEW DEPARTMENT
FAX – 386-615-4058 PHONE – 386-676-7187

EMERGENCY HOSPITALIZATION AUTHORIZATION REQUEST FORM

THIS FORM IS INTENDED TO REPRESENT THE FACILITY'S REQUEST FOR EMERGENCY HOSPITAL ADMISSIONS

This form is not for prior authorization for planned admission or scheduled procedures or surgeries. For more information on prior authorization, please see: https://www.fhcp.com/providers/referrals-authorizations-orders/

FAX FORM & ALL PERTINENT CLINICAL INFORMATION TO FHCP UTILIZATION REVIEW AT 386-615-4058. INCLUDE FACESHEET/DEMOGRAPHICS, EMERGENCY ROOM NOTES, ADMISSION NOTES, PROVIDER NOTES, LABS, RADIOLOGY, PATHOLOGY REPORTS & OTHER DIAGNOSTIC STUDIES

ADMISSION DATE: _____ **ADMISSION TIME:** _____

PATIENT NAME: _____

FHCP MEMBER ID#: _____ **DATE OF BIRTH:** _____

REQUESTING HOSPITAL/FACILITY NAME: _____

FACILITY ADDRESS: _____
Address/City, State

UR/CM CONTACT NAME: _____

PHONE NUMBER: _____ **EXT:** _____ **FAX:** _____

REQUESTED LEVEL OF CARE: ☐ **Hospital Inpatient** ☐ **Hospital Observation**

Estimated length of stay: _____ **Admitting Physician Name/NPI:** _____

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

CPT/HCPC/Revenue Code(s): _____

COMMENTS: