**Florida Community Care LLC**
P.O. Box 261060
Miami, Florida 33126

Florida Community Care
Prior Authorization Form
FAX to 305-675-6138

____ Standard

____ Expedited* (By checking this option, I certify that applying the standard 72 hrs. review time frame may seriously jeopardize the life of health of the patient or the patient's ability to regain maximum function.)

Please complete **all sections** legibly.

Date of Request: ______________________

**MEMBER INFORMATION**

Name: ____________________________ ID Number:__________________________

Date of Birth: ____/____/________ PCP Name: __________________________

Other Insurance: _________________________ Gender (circle one): M F

**REFERRING PHYSICIAN OR PROVIDER INFORMATION**

**Referring Provider/Requesting Provider**

Name: ______________________________

Address: ____________________________

_____________________________________

Phone: ______________________________

Fax: ________________________________

Contact Person: ______________________

Performing Provider/Facility

**Performing Provider/Facility**

Name: ______________________________

Address: ____________________________

_____________________________________

NPI #: ______________________________

TIN # ______________________________

Phone: ______________________________

Fax: ________________________________

Specialty: ____________________________

Signature of Requesting Physician: __________________________________________________

**REFERRAL/AUTHORIZATION INFORMATION**

Diagnosis Code & Description: ____________________________________________________________

CPT/HCPCS Code & Description: __________________________________________________________

Date of Service: ____/____/________ Number of Visits/ Units Requested: ________

**Florida Community Care LLC**
P.O. Box 261060
Miami, Florida 33126

Type of Procedure (Circle one): Inpatient Outpatient In Office

Other Clinical Information (Include clinical notes, labs, radiology reports, etc.): ______________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

If this is a request for reauthorization of a previously approved requested, please provide recent clinical documentation. Please Note: Failure to include correct procedure codes or diagnosis codes may result in a delay in processing the service authorization request.