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

Florida Community Care
Prior Authorization Form
FAX to 305-675-6138
Email: fccumdepartment@fcchealthplan.com

____ 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: _____

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

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.