Communitycare the health plan with a heart PLAN

Broward Regional Health Planning Council
BRHPC
HEALTH & HUMAN SERVICE INNOVATIONS
www.BRHPC.org

PROVIDER REQUEST DATE: _____

FUTURE ADMISSION/SURGERY/PROCEDURE DATE: _____

START OF CARE DATE/ DATES OF SERVICE: _____

PROVIDER: _____ OFFICE REP: _____

AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.

(Failure to complete this form in its entirely may result in the delay of review).

CCP FAX NUMBER: **BRHPC** **954-241-1379**		**REQUESTING FROM PROVIDER NAME:**
CCP PHONE NUMBER : 954-622-3400 **BRHPC**		**REQUESTING TO PROVIDER:**
PCP NAME:	**PCP PHONE #:**	**PROVIDER TO FAX NUMBER:**
MEMBER NAME:	**D.O.B.:**	**PROVIDER TO PHONE NUMBER:**
MEMBER ID NUMBER:		**PROVIDER TO TAX ID NUMBER:**

PRODUCT LINES:

☐ **BRHPC** ☐ **ROUTINE** (PROCESS WITHIN **3** BUSINESS DAYS)	☐ **BRHPC** ☐ **URGENT** (PROCESS WITHIN **2** BUSINESS DAYS)

☐ **NON-PARTICIPATING / OUT OF NETWORK** (REQUIRES AUTHORIZATION REVIEW – ALLOW ADDITIONAL TIME)

Definition of Urgent: A Pre-Service request for which the Routine processing time period could seriously jeopardize the member's life, health or ability to regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the treatment being requested. A Post- Service request for authorization is never an urgent request.

Reason for request: (Attach pertinent medical records to assist in medical necessity review)

Diagnosis _____ ICD-10 _____

Procedure _____ CPT _____

Comment_____

_____

Place of Service: ☐ 11 (Office) ☐ 21 (IP Hospital) ☐ 62 (OP Physical Therapy) ☐ 24 (Ambulatory Surg Ctr)
☐ 12 (Home) ☐ 22 (OP Hospital) ☐ Other_____

Facility /Provider's name where service to be performed: _____

☐ Provider's name_____

Provider's Signature _____ Date_____ **Provider's Printed Name** _____