



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 entirety may result in the delay of review).

CCP FAX NUMBER: BRHPC		954-241-1379	REQUESTING FROM PROVIDER NAME:
CCP PHONE NUMBER: BRHPC		954-622-3400	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:

<input type="checkbox"/> BRHPC <input type="checkbox"/> ROUTINE (PROCESS WITHIN 3 BUSINESS DAYS)	<input type="checkbox"/> BRHPC <input type="checkbox"/> URGENT (PROCESS WITHIN 2 BUSINESS DAYS)
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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 _____

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