Communitycare the health plan with a heart PLAN
P.O. Box 841309, Pembroke Pines, FL 33084
Phone number: 1-866-899-4828

PRIOR AUTHORIZATION REQUEST FORM:
CCP MMA (Medicaid) Fax: 1-844-870-0159
Participating Providers must submit prior authorization requests for medical services via Epic Link/ Plan Link web portal
Prior Auth list and other information available at **www.ccpcares.org**

Priority: ☐ **EXPEDITED** (With complete information, review may take up to 2 days). Provider certifies that applying the standard review time frame may seriously jeopardize the life or health of the enrollee.

☐ **STANDARD** (With complete information, review may take up to 7 days)

Incomplete requests will not be accepted | Include pertinent clinical documents to facilitate review| If Out of Network, provide explanation

ENROLLEE INFORMATION			
Enrollee Name: (First) (MI) (Last)	DOB (mm/dd/yyyy)	Height/ Weight	Gender
Enrollee Medicaid ID #	Enrollee Phone #:		
Enrollee Address:	Other payer info: (Medicare, commercial plan, Long Term Care, Dental plan)		
REQUESTING PROVIDER INFORMATION (check one)	☐ **PCP** ☐ **Specialist**		
Office Contact Name:	Specialty:		
Office/ Clinic/ Practice Name:	Address:		
TIN/ NPI#			
Requesting Provider's Name:	Phone #:	Fax #:	
Requesting Provider's Signature: I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.	Date:		
REFERRED TO PROVIDER INFORMATION (check one)	☐ **In-Network** ☐ **Out-of-Network**		
Provider Name/ Specialty:	Office Contact Name:		
Facility or Practice Name:	TIN/ NPI #	FL Medicaid Provider #	
Address:	Phone #:	Fax #:	
REQUESTED SERVICE TYPE (check one below)	**Date(s) of Service:**		

☐ Ambulatory Surgery Ctr ☐ Chemotherapy ☐ Dialysis ☐ Durable Medical Equipment ☐ Early Intervention Svcs
☐ Epidural Pain Management ☐ Home Health Services ☐ Hospice Services ☐ Hospital Inpatient ☐ Hospital Obs
☐Hospital Outpatient ☐ Hyperbaric treatment ☐ Medical Foster Svcs ☐ Obstetrical Global notification ☐ Office
☐ Therapy Services ☐ Transplant related services ☐ Other (please specify)_____

ICD-10 Code(s) and description

CPT Code(s)/ HCPCS/ units or visits requested and description/ medical reason:

Statement to Provider: This authorization is for Medically Necessary Services Only. Payment is contingent on services being authorized, services being a covered benefit, coordination of benefits, and enrollee eligibility at the time of service. Additionally, it is important that a report of the treatment provided or service(s) recommended be completed on this enrollee and forwarded to the Primary Care Provider within 7 days of services.