



MMCP/MCHP/SBCHS/CCP/CCP HSA

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

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| CCP FAX NUMBER: MMCP/MCHP/SBCHS/CCP/CCP HSA 954-251-4279 | | REQUESTING TO PROVIDER: |
| CCP PHONE NUMBER (Effective 1/1/2016): 954-622-3499 | | REQUESTING FROM PROVIDER NAME: |
| PCP NAME: | PCP PHONE #: | PROVIDER TO FAX NUMBER: |
| MEMBER NAME: | D.O.B.: | PROVIDER TO PHONE NUMBER: |
| MEMBER ID NUMBER: (FOR SBCHS USE MEDICAL RECORD #) | | PROVIDER TO TAX ID NUMBER: |

PRODUCT LINES:

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| <input type="checkbox"/> SBCHS (PCC) SOUTH BROWARD COMMUNITY HEALTH SERVICES <input type="checkbox"/> ROUTINE (PROCESS WITHIN 14 BUSINESS DAYS) | <input type="checkbox"/> MMCP/MCHP/CCP/CCP HSA <input type="checkbox"/> ROUTINE (PROCESS WITHIN 3 BUSINESS DAYS) |
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URGENT (WITHIN 24 HOURS) 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 (Amb Surg Ctr)
 12 (Home) 22 (OP Hospital) Other _____
 Facility /Provider's name where service to be performed: MRH MHW MHP MHM MRHS JDCH
 Other facility _____ Provider's name _____

Provider's Signature _____ Date _____ Provider's Printed Name _____

Please send your claims to: For SBCHS, P.O. Box 849119, Pembroke Pines, FL 33084

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