

Claims Payor ID FHKC1

Phone number: 1-866-930-0944

**PRIOR AUTHORIZATION REQUEST FORM:
 COMMUNITY CARE PLAN - FLORIDA HEALTHY KIDS
 Fax: 1- 866-930-0969**

Participating Providers must submit prior authorization requests for services via Epic Link/ Plan Link web portal. All services rendered by non-participating Providers require authorization. Prior Auth list and other information available at www.ccpcares.org

- Priority:**
- EXPEDITED** (With complete information, review may take up to 72 hours). 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 14 calendar 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 ID #			Enrollee Phone #:		
Enrollee Address:			Other payer info: (Medicare, Commercial plan, Dental plan)		
REQUESTING PROVIDER INFORMATION (check one)			<input type="checkbox"/> PCP <input type="checkbox"/> Specialist		
Office Contact Name:			Specialty:		
Office/ Clinic/ Practice Name:			Address:		
TIN/ NPI#/ FL Medicaid #					
Requesting Provider's Name:			Phone #:	Fax #:	
Requesting Provider's Signature:			Date:		
I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.					
REFERRED TO PROVIDER INFORMATION (check one)			<input type="checkbox"/> In-Network <input type="checkbox"/> 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:		
<input type="checkbox"/> Ambulatory Surgery Ctr <input type="checkbox"/> Behavioral Health/Substance Use Services <input type="checkbox"/> Dialysis <input type="checkbox"/> Durable Medical Equipment <input type="checkbox"/> Hospice Services <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Hospital Observation <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Hyperbaric Treatment <input type="checkbox"/> Maternity (Procedures) <input type="checkbox"/> Out of Network Services <input type="checkbox"/> Prosthetic/Orthotic Devices <input type="checkbox"/> Respiratory Therapy Services <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Transplant Related Services <input type="checkbox"/> Other (please specify) _____					
ICD-10 Code(s) and description					
CPT Code(s) / J Codes/ 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 Requesting and Primary Care Provider within 7 days of services.					

*****CONFIDENTIALITY NOTICE*****

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