Community Care Plan
The Health Plan with a Heart

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)	☐ **PCP** ☐ **Specialist**		
Office Contact Name:	Specialty:		
Office/ Clinic/ Practice Name:	Address:		
TIN/ NPI#/ FL Medicaid #			
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 ☐ Behavioral Health/Substance Use Services ☐ Dialysis ☐ Durable Medical Equipment
☐ Hospice Services ☐ Hospital Inpatient ☐ Hospital Observation ☐Hospital Outpatient ☐ Hyperbaric Treatment
☐ Maternity (Procedures) ☐ Out of Network Services ☐ Prosthetic/Orthotic Devices ☐ Respiratory Therapy Services
☐ Skilled Nursing Facility ☐ Transplant Related Services
☐ 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.