

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.cepcares.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 7 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) **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.

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

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