

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 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)

<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:

- ☐ 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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