FLORIDA HEALTH CARE PLANS REFERRAL FORM

Date: ______________________ Auth #: ______________________

A. Member Name: ______________________

MRN: ____________ Date of Birth: ____________

Home Tel: ____________ Work Tel: ____________

Cell #: ______________________

Subscriber #: ______________________

Parent / Guardian Name: ______________________

Referring Provider Name: ______________________

Referring Provider Phone #: ______________________

Referring Provider FHCP #: ______________________

Provider Signature: ______________________

cc Copy to: ______________________

☐ Referral at Patient Request Only

B. REFERRAL STATUS: ☐ Routine ☐ Urgent

***** For urgent cases requiring prior authorization, the provider office must call Central Referrals Department at (386) 238-3230. *****

Please refer to your Network Referral Instructions for assistance in completing all HMO referrals.

C. REFERRAL IS FOR: ______________________

☐ With Contrast ☐ Without Contrast ☐ With & Without Contrast

❖ DME (equipment needed) ______________________

Length of need for DME required (except for Nebulizers) ______________________

D. DIAGNOSIS CODE ______________________ ☐ Eval ☐ Follow Up ☐ 2nd Opinion ☐ MVA ☐ Pre-existing Status

E. REASON FOR REFERRAL – <u>TO BE COMPLETED BY CLINICIAN</u> *(Attach all Supporting Documentation)*

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F. Appointment with: ______________________ Date: ____________ Time: ____________

Notes: ______________________

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Confirmed with: ____________ By: ____________ On: ____________

G. *THIS SECTION IS ONLY FOR THOSE SERVICES THAT REQUIRE PRE-AUTHORIZATION*

This Form is intended to represent the Provider's order as well as the Services that have been approved by FHCP. Payment will not be authorized for services beyond those as indicated below. Authorization for additional services must be coordinated through the Member's PCP or the Referring Provider.

☐ APPROVED BY FLORIDA HEALTH CARE PLANS FOR: ______________________

Signature: ______________________ Date: ____________

TO: ____________ FROM: ____________ Phone #: ____________