FLORIDA HEALTH CARE PLANS REFERRAL FORM
Phone: 386-238-3230 Fax: 386-238-3253

Date: _____ Auth #: _____

A. Member Name: _____

MRN: _____ Date of Birth: _____

Home Tel: _____ Work Tel: _____

Cell #: _____

Subscriber #: _____

Parent / Guardian Name: _____

Referring Provider Name: _____

Contact/Caller Name: _____

Referring Provider Phone #: _____

Referring Provider FHCP #: _____

Provider Signature: _____

☐ Referral at Patient Request Only

B. REFERRAL STATUS: ☐ Routine ☐ Urgent

Is this the result of an auto or work accident? ☐ Yes ☐ No

***** 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

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

F. Appointment with: _____ Date: _____ Time: _____

Notes: _____

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: _____