Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

FLORIDA HEALTH CARE PLANS
P.O. BOX 9910
DAYTONA BEACH, FL 32120
CENTRALS REFERRALS DEPARTMENT
FAX – 386-238-3253 PHONE – 386-238-3215 / 1-800-729-8349

AUTH #: _____

PRECERTIFICATION FORM

REQUEST FOR PRECERTIFICATION IS **REQUIRED PRIOR TO THE DATE OF SERVICE. THIS FORM IS INTENDED TO REPRESENT THE PROVIDER'S ORDER FOR SERVICES OR SUPPLIES**

PLEASE FAX ALL PERTINENT CLINICAL INFORMATION TO FHCP AT THE NUMBER LISTED ABOVE. THIS MAY INCLUDE LABS, RADIOLOGY, PATHOLOGY REPORTS & OTHER DIAGNOSTIC STUDIES INCLUDING H&P AND/OR PROVIDER NOTES.

TAX ID #: _____

DATE: _____

REQUESTING PROVIDER NAME: _____ TYPE OF REFERRAL:

CONTACT/CALLER NAME: _____ ☐ ROUTINE ☐ URGENT

PHONE NUMBER: _____ EXT: _____ FAX: _____

Patient Name: _____ Date of Birth: _____

FHCP Medical Record #: _____ Patient Phone #(s): _____

A. Surgical Procedure: _____ CPT Code: _____

Diagnosis: _____ ICD-10 Code: _____

Surgical Procedure Date: _____ Surgeon: _____

Facility Name: _____

☐ Inpatient ☐ Outpatient ☐ 23 Hour OBS * Admit Date Expected Length of Stay

*Documentation is required to support 23 Hour OBS status

Pre-Op Testing Date: _____ Physicians Pre-op Visit Date: _____

B. **OFFICE VISIT / TEST REQUESTED: (Name Provider or Test)** _____

☐ Initial evaluation	☐ Follow up	☐ Test With Contrast	☐ Test Without Contrast	☐ Test With & Without Contrast

Appt Date: _____ Testing Facility Name: _____

DX: _____ ICD-10 Code: _____

**** THIS SECTION FOR INTERNAL USE ONLY**** Payment will not be authorized for services beyond those indicated below. ****

☐ Approved by Florida Health Care Plans for: _____

_____

_____

Signature: _____Date:_____