

**Florida Complete Care  
Prior Authorization Form**



Florida Complete Care  
P.O. Box 261060  
Miami, Florida 33126  
FAX: 305-675-6138

Standard

Expedited\*

*By checking this option, I certify that applying the standard prior authorization process of 7-day time frame will seriously jeopardize the life or health status of the patient or the patient's ability to regain maximum function. The specific details as to how this patient would be in jeopardy or unable to regain maximum function must be written below in the Pertinent Clinical Information Section. An expedited review cannot be performed unless this information is included and evaluated. Requests for expedited review which fail to provide the required specific detail as defined above will be placed into standard review.*

**If this is a request for reauthorization of a previously approved request that has expired, please provide the authorization number.**

*Please complete **all sections** by printing legibly.*

Date of Request:			
<b>Member Information</b>			
Member ID Number:			
First Name:		Last Name:	
Date of Birth:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
PCP Name:			
PCP Phone:			
Primary Insurance:			
Secondary Insurance:			
<b>Referring Provider / Requesting Provider</b>		<b>Servicing Provider / Facility Requested</b>	
Name:		Name:	
Address:		Address:	
Phone:		NPI #:	
Fax:		TIN #:	
Contact Person:		Phone:	
Signature of Referring Physician or Provider:		Fax:	
		Specialty:	

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Referral / Authorization Information			
Primary Diagnosis or Description:			
Type of Service:			
<input type="checkbox"/> 1. Medical Care	<input type="checkbox"/> 4. Diagnostic Radiology	<input type="checkbox"/> 7. Anesthesia	
<input type="checkbox"/> 2. Surgery	<input type="checkbox"/> 5. Diagnostic Laboratory	<input type="checkbox"/> 8. Assistant at Surgery	
<input type="checkbox"/> 3. Consultation	<input type="checkbox"/> 6. Therapeutic Radiology	<input type="checkbox"/> 9. Other Medical Item or Service	
CPT/HCPCS Code or Description:			
Start Date of Service:		Number of Visits / Units Requested:	
Place of Service (Select one):			
Inpatient:	<input type="checkbox"/> 21		
Outpatient:	<input type="checkbox"/> 19	<input type="checkbox"/> 22	<input type="checkbox"/> 24
In Office:	<input type="checkbox"/> 11		
Pertinent Clinical Information Relevant to the Referral (Include clinical notes, labs, radiology reports, etc.):			

*Please Note: Failure of not filling out this form in its entirety nor including the applicable procedure codes or diagnosis codes and supporting document attachments will result in a delay in processing or refusal of this prior authorization request.*