CCP OUT-OF-STATE AUTHORIZATION REQUEST FORM

Fax requests to (844) 806-0397. Questions call T19: (866) 209-5022 T21: (866) 202-1132
To find forms on our website visit http://ccpcares.org/providers/provider-resources

Section 1: Member Info and Type of Request

Member: _____ **DOB:** _____ **Member ID#:** _____ **Age:** _____ **Gender:** _____

Program: ☐ **Title XIX (T19 MMA-CMS Plan)** ☐ **Title XXI (T21)**

Request Type: ☐ **Standard** ☐ **STAT*** ☐ **Retro** (service already provided)

**Standard timeframe could seriously jeopardize the member's life, health, or ability to obtain, maintain, or regain maximum function.*

Diagnosis Code(s):_____

Referring Provider Name: _____ **Phone #:** _____ **Contact Name:** _____

PCP Name (if not referring provider): _____ **Phone #:** _____ **Contact Name:** _____

CMS Nurse Care Coordinator: _____ **Phone #**: _____

Requested Dates of Service: _____ through _____

Section 2: Clinical Information – Please attach clinical documentation and additional pages if more space is needed below.

Provide summary of attempts to use Florida providers and how this member's needs cannot be provided within Florida:

Describe the out-of-state treatment plan for this visit and the expected number of follow-up visits:

Describe the plan for transitioning the member's treatment to a Florida provider:

Section 3: Information for Out-of-State Provider(s) Involved (Facilities/Specialists) – Please attach additional pages if necessary.

New Patient	Facility Name	Specialty	Procedure(s)	Procedure Code(s)
Y / N				

Provider Address	Contact Name	Contact Phone	Contact Fax

FL Medicaid Provider	If yes, FL Medicaid ID#	Accept OOS Medicaid	Tax ID #	NPI #
Y / N		Y / N		

New Patient	Provider Name	Specialty	Procedure(s)	Procedure Code(s)
Y / N				

Provider Address	Contact Name	Contact Phone	Contact Fax

FL Medicaid Provider	If yes, FL Medicaid ID#	Accept OOS Medicaid	Tax ID #	NPI #
Y / N		Y / N		

New Patient	Provider Name	Specialty	Procedure(s)	Procedure Code(s)
Y / N				

Provider Address	Contact Name	Contact Phone	Contact Fax

FL Medicaid Provider	If yes, FL Medicaid ID#	Accept OOS Medicaid	Tax ID #	NPI #
Y / N		Y / N		

Comments/Additional Information: