MMCP/MCHP/SBCHS/CCP/CCP HSA

PROVIDER REQUEST DATE: _________

FUTURE ADMISSION/SURGERY/PROCEDURE DATE: ____________________

START OF CARE DATE/ DATES OF SERVICE: ___________________________

PROVIDER: __________________ **OFFICE REP:** ______________________

AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT

SFCCN FAX NUMBER: MMCP/MCHP/SBCHS/CCP/CCP HSA **954-251-4279**		**REQUESTING TO PROVIDER:**
SFCCN PHONE NUMBER (Effective 1/1/2016): **954-622-3499**		**REQUESTING FROM PROVIDER NAME:**
PCP NAME:	**PCP PHONE #:**	**PROVIDER TO FAX NUMBER:**
MEMBER NAME:	**D.O.B.:**	**PROVIDER TO PHONE NUMBER:**
MEMBER ID NUMBER: (FOR SBCHS USE MEDICAL RECORD #)		**PROVIDER TO TAX ID NUMBER:**

PRODUCT LINES:

☐ **SBCHS (PCC)** SOUTH BROWARD COMMUNITY HEALTH SERVICES ☐ **ROUTINE** (PROCESS WITHIN **14** BUSINESS DAYS)	☐ **MMCP/MCHP/CCP/CCP HSA** ☐ **ROUTINE** (PROCESS WITHIN **3** BUSINESS DAYS)

☐ **URGENT** (WITHIN **24** HOURS) ☐ **NON-PARTICIPATING / OUT OF NETWORK** (REQUIRES AUTHORIZATION REVIEW – ALLOW ADDITIONAL TIME)

Definition of Urgent: A Pre-Service request for which the Routine processing time period could seriously jeopardize the member's life, health or ability to regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the treatment being requested. A Post- Service request for authorization is never an urgent request.

Reason for request: (Attach pertinent medical records to assist in medical necessity review)

Diagnosis ____ ICD-10 ________________________________

Procedure ____ CPT ________________________________

Comment____

____

Place of Service: ☐ 11 (Office) ☐ 21 (IP Hospital) ☐ 62 (OP Physical Therapy) ☐ 24 (Amb Surg Ctr)
☐ 12 (Home) ☐ 22 (OP Hospital) ☐ Other_______________

Facility /Provider's name where service to be performed: ☐ MRH ☐ MHW ☐ MHP ☐ MHM ☐ MRHS ☐ JDCH

☐ Other facility ______________________________ ☐ Provider's name________________________________

Provider's Signature ____________________ Date_________ **Provider's Printed Name** ______________________

Please send your claims to: **For SBCHS, P.O. Box 849119, Pembroke Pines, FL 33084**

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For MMCP/MCHP/ CCP/CCP HSA P.O. Box 849029, Pembroke Pines, FL 33084