PPUC PRIOR AUTHORIZATION REQUEST FORM

Fax: 954-699-0737 | CCP.FAX.PPUC@CCPCARES.ORG Request Date: _____

Include pertinent clinical documents to facilitate review | INCOMPLETE REQUESTS WILL NOT BE ACCEPTED

Please check priority of request: ☐ Emergent/ Stat – within 1 business ☐ day Urgent – within 3 business days ☐ Routine – within 14 business days	Start of Service Date ___ Office Contact Name: __ Office contact Phone/ Fax:

PATIENT INFORMATION:

Last Name: _____First Name: _____ DOB:

Patient ID#:_____ Gender: _____Patient Phone # _____

Patient Address:

PROVIDER INFORMATION:

Requestor: PCP Specialist	Service Provider Information:
Requestor's Name:	Service Provider Name:
Specialty:	Service Provider Address:
Phone number:	Phone number:
Fax number:	Fax number:

SERVICE(S) REQUESTED:

Planned Service(s) or Procedure(s)	CPT/ HCPCS	Diagnosis Description	ICD-10

Type of Service (check one): ☐ Consult ☐ Follow up ☐ PT ☐ OT ☐ ST ☐ Other
☐ HH ☐ DME ☐ Infusion ☐ Cardiac Rehab ☐ Wound Care

Request for #:_____ Visits _____ Weeks _____Units _____ Treatments _____

Place of Service: ☐ OFFICE ☐ HOSPITAL OUTPATIENT ☐ HOSPITAL OBSERVATION ☐ HOSPITAL INPATIENT

Facility: ☐ BHMC ☐ BHN ☐ BHIP ☐ BHCS ☐ Other_____.

*********CONFIDENTIALITY STATEMENT*********

The information contained in this telecopy transmission contains confidential information, belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you received this telecopy in error, please notify the Requesting Provider immediately to arrange for return or destruction of these documents.