

P.O. Box 841309, Pembroke Pines, FL 33084 Phone number: 1-866-899-4828

PRIOR AUTHORIZATION REQUEST FORM: CCP MMA (Medicaid) Fax: 1-844-870-0159

Participating Providers must submit prior authorization requests for medical services via Epic Link/ Plan Link web portal

Prior Auth list and other information available at www.ccpcares.org

Priority:

□ **EXPEDITED** (With complete information, review may take up to 2 days). Provider certifies that applying the standard review time frame may seriously jeopardize the life or health of the enrollee.

☐ **STANDARD** (With complete information, review may take up to 7 days)

Incomplete requests will not be accepted | Include pertinent clinical documents to facilitate review | If Out of Network, provide explanation

ENROLLEE INFORMATION							
Enrollee Name: (First) (MI) (Last)	DOB (mm/dd/yyyy)	Height	t/ Weight	Gender		
Enrollee Medicaid ID #	Enrollee Phone #:						
Enrollee Address:		Other payer info: (Medicare, commercial plan, Long Term					
		Care, Dental plan)	e, Dental plan)				
REQUESTING PROVIDER INF	□ РСР	☐ Specialist					
Office Contact Name:	Specialty:						
Office/ Clinic/ Practice Name:	Clinic/ Practice Name:			Address:			
TIN/ NPI#							
Requesting Provider's Name:		Phone #:	Fax #:				
Requesting Provider's Signatur	Date:						
I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.							
REFERRED TO PROVIDER INF	☐ In-Network ☐ Out-of-Network						
Provider Name/ Specialty:		Office Contact Name	Office Contact Name:				
Facility or Practice Name:		TIN/ NPI # FL Medicaid Provider		rovider #			
Address:		Phone #:	F	Fax #:			
REQUESTED SERVICE TYPE (check one below) Date(s) of Service:							
☐ Ambulatory Surgery Ctr ☐ Chemotherapy ☐ Dialysis ☐ Durable Medical Equipment ☐ Early Intervention Svcs							
☐ Epidural Pain Management ☐ Home Health Services ☐ Hospice Services ☐ Hospital Inpatient ☐ Hospital Obs							
☐ Hospital Outpatient ☐ Hyperbaric treatment ☐ Medical Foster Svcs ☐ Obstetrical Global notification ☐ Office							
☐ Therapy Services ☐ Transplant related services ☐ Other (please specify)							
ICD-10 Code(s) and description							
CPT Code(s)/ HCPCS/ units or visits requested and description/ medical reason:							
Statement to Durviden This systemination is for Medically Necessary Comices Only Durviden to the statement of the system of the							
Statement to Provider: This authorization is for Medically Necessary Services Only. Payment is contingent on services being authorized, services being a covered benefit, coordination of benefits, and enrollee eligibility at the time of service. Additionally, it is important that a report of the treatment provided or							

service(s) recommended be completed on this enrollee and forwarded to the Primary Care Provider within 7 days of services.

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

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