



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.**

Failure to complete this form in its entirety may result in the delay of review  
Attach pertinent medical records to assist in medical necessity review.

CCP FAX NUMBER: BROWARD COUNTY GOV'T (BCG) <b>954-417-7104</b>		REQUESTING FROM PROVIDER NAME:
CCP PHONE NUMBER : <b>1-866-224-5701</b> BCG		REQUESTING TO PROVIDER:
PCP NAME:	PCP PHONE #:	PROVIDER TO FAX NUMBER:
MEMBER NAME:	D.O.B.:	PROVIDER TO PHONE NUMBER:
MEMBER ID NUMBER:		PROVIDER TO TAX ID NUMBER:

REQUEST TYPE:

<input type="checkbox"/> <b>ROUTINE</b> (PROCESS WITHIN 7 BUSINESS DAYS)	<input type="checkbox"/> <b>URGENT</b> (PROCESS WITHIN 3 BUSINESS DAYS)
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**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) ☐ 24 (Ambulatory Surg Ctr)  
☐ 12 (Home) ☐ 22 (OP Hospital) ☐ Other \_\_\_\_\_

Facility /Provider's name where service to be performed: \_\_\_\_\_  
☐ Provider's name \_\_\_\_\_

Requesting Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

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