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)** **954-417-7104**		**REQUESTING FROM PROVIDER NAME:**
CCP PHONE NUMBER : 1-866-224-5701 **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:

☐ **ROUTINE** (PROCESS WITHIN 7 BUSINESS DAYS)	☐ **URGENT** (PROCESS WITHIN 3 BUSINESS DAYS)

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_____