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_____