



FROVIDER REQUEST DATE	•		
FUTURE ADMISSION/SURG	ERY/PROCED	URE DA	ΓΕ:
START OF CARE DATE/ DATES OF SERVICE:			
PROVIDER: OFFICE REP:			
AUTHORIZAT Failure to comple	ION IS NOT te this form in its	A GUA	RANTEE OF PAYMENT. nay result in the delay of review 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)	
health or ability to regain maximum function the treatment being requested. A Post- Se	on; or would subject the rvice request for author	e member to orization is ne	
Reason for request: (Attach pertinent	medical records to a	assist in me	•
Diagnosis Procedure		ICD-10 CPT	
Comment			
Facility /Provider's name where service to be	22 (OP Hospital) e performed:	☐ Other_	abulatory Surg Ctr)
☐ Provider's name			
Requesting Provider's Signature		Date	

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