

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 services via Epic Link/ Plan Link web portal. All services rendered by non-participating Providers require authorization. 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)

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

Enrollee Name: (First) (MI) (Last) DOB (mm/dd/yyyy) Height/ Weight Gender Enrollee Medicaid ID # Enrollee Address: Other payer info: (Medicare, commercial plan, Long Terrocare, Dental plan) REQUESTING PROVIDER INFORMATION (check one) PCP Specialist Office Contact Name: Specialty: Office/ Clinic/ Practice Name: Address: TIN/ NPI# Requesting Provider's Name: Phone #: Fax #:	
Enrollee Medicaid ID # Enrollee Address: Other payer info: (Medicare, commercial plan, Long Term Care, Dental plan) REQUESTING PROVIDER INFORMATION (check one) Office Contact Name: Office/ Clinic/ Practice Name: TIN/ NPI#	
Enrollee Address: Other payer info: (Medicare, commercial plan, Long Terricare, Dental plan) REQUESTING PROVIDER INFORMATION (check one) Office Contact Name: Office/ Clinic/ Practice Name: TIN/ NPI# Other payer info: (Medicare, commercial plan, Long Terricare, Dental plan) Address: Address:	
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REQUESTING PROVIDER INFORMATION (check one) Office Contact Name: Office/ Clinic/ Practice Name: TIN/ NPI# Care, Dental plan) PCP Specialist Specialty: Address:	
REQUESTING PROVIDER INFORMATION (check one) Office Contact Name: Office/ Clinic/ Practice Name: TIN/ NPI# PCP Specialist Specialty: Address:	
Office Contact Name: Office/ Clinic/ Practice Name: TIN/ NPI# Specialty: Address:	
Office/ Clinic/ Practice Name: TIN/ NPI# Address:	
TIN/ NPI#	
Requesting Provider's Signature: Date:	
I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.	
REFERRED TO PROVIDER INFORMATION (check one)	
Provider Name/ Specialty: Office Contact Name:	
Facility or Practice Name: TIN/ NPI # FL Medicaid Provider	‡
Address #s For #s	
Address: Phone #: Fax #:	
REQUESTED SERVICE TYPE (check one below) Date(s) of Service:	
☐ Ambulatory Surgery Ctr ☐ Behavioral Health/Substance Use Services ☐ Dialysis ☐ Durable Medical Equipm	ent
☐ Epidural Pain Management ☐ Hospice Services ☐ Hospital Inpatient ☐ Hospital Obs ☐ Hospital Outpatient	2110
☐ Hyperbaric Treatment ☐ Maternity (Procedures) ☐ Nursing Home Facility ☐ Out of Network Services	
☐ Physician Office Administered Drugs (see J-Code list) ☐ Prosthetic/Orthotic Devices	
☐ Respiratory Therapy Services ☐ Transplant related services	
☐ Other (please specify)	
ICD-10 Code(s) and description	
CPT Code(s)/ J Codes / HCPCS/ units or visits requested and description/ medical reason:	
CFT Code(s)/ 3 Codes / HCFC3/ drifts of visits requested and description/ medical reason.	
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, of 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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