Prior Authorization Fax Form
Complete this Form and Fax to 1-866-796-0526
Incomplete Forms Will Be Returned for Resubmission

☐ **Standard Request – Determination will be issued within 14 Calendar days of receiving the request for service.**
☐ **Urgent Request** – By checking this box, I certify that this is an urgent request for a medically necessary service for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received. A determination for urgent pre-service care will be issued within 72 hours of receiving the request for service.
ALL URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN, IN ORDER TO BE PROCESSED AS AN URGENT REQUEST.

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Signature of Requesting Provider

Requesting Provider Name: __________________________ **Requesting Provider Tel:** __________________
Requesting Provider Fax:__________________________ **Date of Request:** _____________

Patient Information		
Name (Last, First, Middle Initial):		**Date of Birth:**
Member Medicaid ID#		
Other Insurance (if Yes) Name and Policy #:		
- Must Be Completed -		
Referring To Specialist and /or Facility: ☐ Participating ☐ Non-Participating		
Specialist / Facility Name:		Specialty / Facility Type:
Address/Location:		
City:	Zip:	Telephone:

Purpose of Referral:

☐ Consult Only	☐ Diagnostic / Radiology	☐ Therapy PT/OT/ST
☐ Consult w/Treatment	☐ Outpatient Surgery	☐ Other (please specify)
☐ Follow-up Visit	☐ Inpatient Admission	
☐ Consult & Follow-up Visit		

PLEASE SEND WITH THIS FORM COPIES OF APPROPRIATE SUPPORTING CLINICAL INFORMATION FOR ALL CASES

Diagnosis / Reason:	ICD-9 Code(s):
Service/Procedure Requested/CPT Code:	Requested Dates of Service:

TO BE USED BY HEALTH PLAN STAFF

Approved: __________ **Units approved:** ________________ **Authorization Number:** ________________ **Authorization Start Date:**________________ **Authorization End Date:** ________________	**Decision Date:** **Reviewer:**
Denied____________	**Prior Authorization Dept. Phone Number 1-866-796-0530**

Disclaimer: Authorization is contingent upon the following: At the time services are rendered, beneficiary is eligible for services and services are a covered Sunshine State Health Plan Benefit. An authorization is not a guarantee of payment. All services must be Coordinated by the Primary Care Physician. **Please mail or fax a copy of the consultation/follow up report to the PCP within 7-10 business days of visit.**
Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.