

# FLORIDA MEDICAID CLAIMS ORDER FORM



## TO COMPLETE FORM

NON-CHARGEABLE FORMS	
Simply CIRCLE <i>QUANTITY REQUESTED</i> for the desired form type needed.	
QUANTITY	
You can only order 100 of each form type at a time using this order sheet. Please submit multiple Claim Order Forms to order additional quantities or online at <a href="http://www.mymedicaid-florida.com">www.mymedicaid-florida.com</a>	
CHARGEABLE FORMS	
For Chargeable Forms please order online at <a href="http://www.mymedicaid-florida.com">www.mymedicaid-florida.com</a>	
SHIPPING & HANDLING	
There is NO shipping charge on non-chargeable forms.	
SHIPPING ADDRESS	
Type or Print your Provider Name, Medicaid provider number, and address in the "TO" box.	
MAIL	
<b>Mail Order Form to:</b>	
Claim Form Orders P.O. Box 7054 Tallahassee, FL 32314-7054	
<b>NOTE: We must have a STREET ADDRESS as we cannot ship to a post office box.</b>	
Date: _____ <input type="checkbox"/> Exempt Provider	
Operator: _____	
NOTES:	

ITEM	FORM TYPES (NON-CHARGEABLE)	QUANTITY REQUESTED
14	TRANSPORTATION PUBLIC 141	100
15	PRIOR AUTHORIZATION PA 01	100
16	DENTAL PRIOR AUTHORIZATION DPA 1041	100
18	DRUG UNIT DOSE RETURN UDR 1014	100
20	INQUIRY RESPONSE IR 05	100
22	STERILIZATION CONSENT SCF	100
23	HYSTERECTOMY ACKNOWLEDGMENT HAF	100
24	EXCEPTION TO HYSTERECTOMY ACKNOWLEDGEMENT ETA	100
25	ABORTION CERTIFICATE ACF	100
27	HOSPICE REFERRAL 0100 AHCA 20	100
28	HOSPICE ELECTION STATEMENT 0100 AHCA 21	100
29	HOSPICE REVOCATION/ CHANGE 0100 AHCA 22	100
30	HOSPICE CHANGE OF STATUS 0100 AHCA 23	100
31	NOTICE OF HOSPICE ELECTION 0100 AHCA 24	100
32	CLAIM/ ADJUSTMENT FORM 0100 MED SERV FORM 038	100

CLAIM FORM ORDERS											
2671 EXECUTIVE CENTER CIRCLE											
SUITE 100											
TALLAHASSEE, FL 32301											
MEDICAID PROVIDER NUMBER											
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TO:	PROVIDER NAME										
	ATTENTION										
	STREET ADDRESS (NO P.O. BOX ALLOWED)										
	CITY, STATE, ZIP CODE										