

Return to:
P.O. BOX 7090,
TALLAHASSEE, FL 32314-7090



STATE OF FLORIDA
FLORIDA MEDICAID
AUTHORIZATION REQUEST



Please check box:

Hospital

- Prior Authorization
- Post Authorization

Physician

- Prior Authorization
- Post Authorization

- Other** (excludes dental)

Post Authorization Date of Service: _____

I. General Information

Recip. Number- 10 digits	Last Name	First Name	Date of Birth
Diagnosis	Procedure Code	Procedure Description	Quantity

EXPLANATION OF NECESSITY FOR PROCEDURES (Attach supportive x-rays, lab reports, operative notes, and discharge summaries etc. if indicated)

II. PROVIDER INFORMATION **AGENCY USE ONLY:**

Medicaid Provider Number: _____

I certify that the information given in this form is a true and accurate medical indication for the procedures requested. All other treatment to correct this problem has been exhausted.

Signature of Provider Date

Provider Name: _____

Address: _____

Contact Name: _____

Contact Phone Number: _____

Date: _____

Approved P.A. Number _____

 Proc. Code _____

 Amount _____

Denied Reason _____

Additional Info. Specify: _____

Reviewed by:

Signature Date

Approved authorizations do not guarantee payment, but are contingent upon recipient and provider *Eligibility* on the *Date of Service*, and services being provided not more than 120 days from the date of authorization.