



# PED-I-CARE OUT-OF-STATE AUTHORIZATION REQUEST FORM

Fax requests to (866) 256-2015. For questions call (800) 492-9634.

To find forms on our website visit <http://pedicare.pediatrics.med.ufl.edu>.



## Section 1: Member Info and Type of Request

Member: \_\_\_\_\_ DOB: \_\_\_\_\_ Member ID#: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Program:  Title XIX (T19 MMA-CMS Plan)  Title XXI (T21)

Request Type:  Standard  STAT\*  Retro (service already provided)

*\*Standard timeframe could seriously jeopardize the member's life, health, or ability to obtain, maintain, or regain maximum function.*

Diagnosis Code(s): \_\_\_\_\_

Referring Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Contact Name: \_\_\_\_\_

PCP Name (if not referring provider): \_\_\_\_\_ Phone #: \_\_\_\_\_ Contact Name: \_\_\_\_\_

CMS Nurse Care Coordinator: \_\_\_\_\_ Phone #: \_\_\_\_\_

Requested Dates of Service: \_\_\_\_\_ through \_\_\_\_\_

## Section 2: Clinical Information – Please attach clinical documentation and additional pages if more space is needed below.

Provide summary of attempts to use Florida providers and how this member's needs cannot be provided within Florida:

Describe the out-of-state treatment plan for this visit and the expected number of follow-up visits:

Describe the plan for transitioning the member's treatment to a Florida provider:



**Section 3: Information for Out-of-State Provider(s) Involved (Facilities/Specialists) – Please attach additional pages if necessary.**

New Patient	Facility Name	Specialty	Procedure(s)	Procedure Code(s)
<input type="checkbox"/> Y <input type="checkbox"/> N				
Provider Address		Contact Name	Contact Phone	Contact Fax
FL Medicaid Provider	If yes, FL Medicaid ID#	Accept OOS Medicaid	Tax ID #	NPI #
<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		

New Patient	Provider Name	Specialty	Procedure(s)	Procedure Code(s)
<input type="checkbox"/> Y <input type="checkbox"/> N				
Provider Address		Contact Name	Contact Phone	Contact Fax
FL Medicaid Provider	If yes, FL Medicaid ID#	Accept OOS Medicaid	Tax ID #	NPI #
<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		

New Patient	Provider Name	Specialty	Procedure(s)	Procedure Code(s)
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<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		

**Comments/Additional Information:**