



# PINELLAS COUNTY HEALTH PLAN AUTHORIZATION FORM



PLEASE PRINT CLEARLY  
FAX to: 727-582-7967

## Requesting Physician

Requesting Physician: \_\_\_\_\_

Medical Home: \_\_\_\_\_

Contact person: \_\_\_\_\_ Ext: \_\_\_\_\_ Date: \_\_\_\_\_

## Client Information

Client Label	-OR-
	Clients Name: _____
	DOB: _____ SS#: _____
	Phone #: _____

Diagnosis & Codes (All): \_\_\_\_\_ (\_\_\_\_) - \_\_\_\_\_ (\_\_\_\_) - \_\_\_\_\_ (\_\_\_\_)

## Service Requested

Place of Service (provide service location below)	Type of Service	Diagnostic Only (Please specify body part)
<input type="checkbox"/> Office Visit	<input type="checkbox"/> Consult and Evaluation Only	<input type="checkbox"/> X-Ray
<input type="checkbox"/> Ambulatory Surgical Center	<input type="checkbox"/> Consult and Treat	<input type="checkbox"/> DEXA Scan
<input type="checkbox"/> Diagnostic Imaging Center	<input type="checkbox"/> Oncology	<input type="checkbox"/> CT Scan
<input type="checkbox"/> Inpatient Hospital	<input type="checkbox"/> Surgical Procedure	<input type="checkbox"/> ECHO
<input type="checkbox"/> Outpatient Hospital	<input type="checkbox"/> Other:	<input type="checkbox"/> Screening Mammogram
<input type="checkbox"/> Other?		<input type="checkbox"/> Diagnostic Mammogram
		<input type="checkbox"/> MRI
Service Location:		<input type="checkbox"/> Ultrasound
		<input type="checkbox"/> PET
		<input type="checkbox"/> Other

Specialist Name (Physician): \_\_\_\_\_

Name of Practice: \_\_\_\_\_ Specialist Type: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Additional Information: \_\_\_\_\_

FOR COMPLETION BY UM STAFF ONLY: <input type="checkbox"/> PENDING (Missing: _____)
<input type="checkbox"/> APPROVED # Visits: _____ Valid Thru: _____ <input type="checkbox"/> NOT-APPROVED (Reason: _____)
Reviewed By: _____ Date: _____
<b>Note: All Labs and Pathology MUST go through LabCorp</b>