Friday Health Plans – Authorization/Referral Request

1-800-475-8466 (P) | 1-888-500-1513 (f) | medical@fridayhealthplans.com

Notice: In accord with the Friday Health Plans (FHP) Member, all referrals (other than on an emergency basis) must be sent by participating providers and be approved in advance by the FHP Medical Director. Care must be completed within the time period indicated. Notification of emergency referrals must be submitted to the FHP Medical Director within 48 hours after referrals are made. Referral requests received more than 10 business days after the service was provided with be denied.
This authorization is limited to the care/treatment indicated for the stated diagnosis/problem. Approval of this request for referral authorization does not authorize the provision of services in excess of those benefits currently provided under the member's service agreement with Friday Health Plans. For services to be covered, the member must be enrolled at the time the service is provided. Payment is subject to verification of eligibility w/in 2 business days prior to the delivery of services. Friday Health Plans verification of eligibility is made based upon records at hand. Payment for this claim will not be made if member's premium has not been paid to Friday Health Plans for the period in which the date of service occurs. Friday Health Plans will pay the contracted fee or an amount not to exceed usual/ customary/reasonable charges. Specialty care provider agrees to accept Friday Health Plans payment as payment in full (except for applicable deductible/co-payment/ coinsurance) and holds harmless the member for any amount owed by Friday Health Plans

Incomplete requests will be returned. In order to be considered for review, requests must be legible and must include the following:

1) A completed copy of the FHP Request for Authorization/Referral Request form (below),
2) Clinical dictation &/or supporting documentation relating to requested service(s),
3) The referring physician's signature/E-signature or written signed order

Patient/Member Information

Name: ______________________________
DOB: ______________ CCHP ID #: ______________
Other Insurance? ☐ Yes ☐ No   If Yes, Information:
____
Is the requested service work related? ☐ Yes ☐ No
Is the requested service auto related? ☐ Yes ☐ No

Whom should we contact if we have follow up questions?
Name: ______________________________
Phone: ______________ Fax: ______________

Referring Physician/Provider Information

Name: ______________________________
Tax ID#: ______________________________
Phone: ______________ Fax: ______________
Address: ______________________________

Referring to (hospital/surgical center/imaging center)
Facility: ______________________________
Tax ID#: ______________________________
Phone: ______________ Fax: ______________
Address: ______________________________

Referring to (If different than the referring)
Provider: ______________________________
Tax ID#: ______________________________
Phone: ______________ Fax: ______________
Address: ______________________________

Service(s) being requested (Brief description with associated codes)

Brief Description **Check if: ☐ Inpatient or ☐ Outpatient**	CPT/HCPCS	ICD-10	DOS[1]

______________________________ ______________
Doctor's Signature Date

[1] Enter all service dates scheduled

The results of the care of treatment rendered by the specialty care provider under this referral authorization must be forwarded to the FHP referring physician named for inclusion in the patient's medical record. Authorization is not required for in-network specialist office visits billed alone. If additional services are performed during visit, authorization may be required. For plan w/ out-of-network benefits, a prior authorization is not required for office visits, whether in- or out-of-network.