Fax Cover Sheet for Medical Records

All Requests must be typed or completed electronically then printed and attached to this cover sheet with your medical records (Do not write by hand.)



Include a completed associated Certificate of Medical Necessity (CMN) for the requested care or treatment.

	PSS: (877) 219-9448			Preservice Medical Review Department	
Rx: (904) 905-984			Pr	none: (800) 955-5692 / Option 3 / Option 8	
Transplant: (904)		M M W DDOE	(00.1) 201 1 (11		
		M, Medicare PPO Fax:			
Preservice Request	ge, Florida Blue Medica Fax.: (866) 441-1569 ervice Request Fax.: (8	are Part B Rx Fax: (904) 35	7-6699 FEP		
Authorization/Refe	-	00) 441-1300			
D.£				Dete(/dd/).	
Ref:				Date(mm/dd/yyyy):	
Physician Informat	tion/Requesting Pro	vider			
Physician Name:			Provider Number:	National Provider Identifier (NPI)	
,					
Sender/Contact Name:			Phone:	Fax Number:	
Patient Information	n				
Patient Name:			DOB(mm/dd/yyyy):	Patient Policy Number:	
Request Type	C411	D 11: 1			
Request Type	Standard	Expedited			
				making a non-urgent care determination	
				num function, based on a prudent lay ndition, would subject the member to	

Action: If you are not the intended recipient or the individual responsible for delivering to the intended recipient, be advised that any use, dissemination, forwarding, or copying of this document is strictly prohibited. Notify the sender immediately by telephone and destroy

Notes: The information in this document is confidential and intended solely for the use of the individual or entity to whom it is addressed.

this document immediately.

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severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

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