INCIDENTAL EXPENSE
PRE-AUTHORIZATION FORM

CLIENT INFORMATION

Client Name: _____ **DOB:** _____ **SS #:** _____

Primary Diagnosis: _____ **Secondary Diagnosis:** _____

PROVIDER INFORMATION

Provider Name: _____ **Contact Person:** _____

Contact Number: _____ **Email:** _____

REQUEST FOR SERVICE FUNDING

Total Amount requested : $ _____ **# of items/units** _____ **Length of Need** _____

(If requesting a service, list rate per hour)

Description of goods/services requested (Include procedure code and narrative):

General reason for request/benefit to client (Include treatment goal being addressed):

Alternatives explored:

Vendor Name	Vendor Address

_____ _____

Provider Representative Signature **Date**

TO BE COMPLETED BY CENTRAL FLORIDA CARES:

Incidental Expense Request: ☐ Approved ☐ Denied

Amount Approved: $ _____ **Authorization Expiration Date:** _____

Reason For Denial: _____

_____

System of Care Signature: _____ **Date:** _____

Contract Manager Signature: _____ **Date:** _____

DISCLAIMER: This authorization does not guarantee available funds in the subcontractor's contract.

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