TEMPORARY SERVICE AUTHORIZATION

Recipient name: _____

Recipient Medicaid number: _____

Date of service(s): _____

Service(s) provided: _____

_____

_____

Medicaid procedure code(s): _____

_____

_____

I have reviewed the relevant clinical information and confirm that the service(s) provided was (were) medically necessary.

_____ _____

Treating Practitioner's Signature Date

_____

Treating Practitioner's Name

To be placed in the recipient's medical record.

AHCA Form 5000-3510, Revised December 2012 (incorporated by reference in Rule 59G-4.050, F.A.C.)