FIDELIS CARE®

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DME Authorization Request

*Indicates a required field

Requirements: *Clinical information and supportive documentation should consist of current physician order, notes and recent diagnostics. Notification is required for any date of service change.* ***Expedited Requests:*** If the standard time for making a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call (888) 453-2534.

Fax completed form to: (877) 431-8859

Requestor Name: _____ Fax*: _____ Phone*: _____

MEMBER INFO (Please Print)		
ID Number*:	Medicaid/Medicare ID:	
Last Name*:	First Name, MI*:	Date of Birth*: / /

ORDERING PROVIDER (Please Print)		
ID Number:	NPI/Tax ID*:	
Provider Name*:	Address:	
City, State, ZIP:	Fax*:	Phone:

DISPENSING PROVIDER* (Please Print)			
ID Number:	☐ Plan to Assign	NPI/Tax ID*:	
Provider Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:

REQUESTED EQUIPMENT* (Please Print) Please submit separate requests for Prosthetics vs. Orthotics and Purchases vs Rentals	
☐ Prosthetic ☐ Orthotics	☐ Purchase ☐ Rental x____ Months
Is item needed for discharge? (circle one) Y/N	Discharge Date: ____/____/_____
Has this item been dispensed*? (circle one) Y/N	Dispense Date: ____/____/_____

ICD-10 Code*:	ICD-10 Code:	ICD-10 Code:	ICD-10 Code:

HCPC Code*:	Description:	Units:
HCPC Code:	Description:	Units:
HCPC Code:	Description:	Units:
HCPC Code:	Description:	Units:
HCPC Code:	Description:	Units:

Please include additional clinicals, as well as additional codes (if needed)