FIDELIS CARE®

Medication Appeal Request

Please fax request to 1-888-865-6531 along with all pertinent medical records.
Please contact the Customer Service department for any questions you may have.
Complete each section legibly.

The appeal request is being initiated by (please only check one option):
☐ Provider (or office staff member acting on behalf of provider) ☐ Member ☐ Appointed Representative

Member's Name:	Date of Request:	**Name of person requesting this appeal and their relationship to the member:**
Member ID#: LOB: Plan Code:		**Original Coverage Determination Date:** **Ticket #:**
Date of Birth:		**Requester's Phone Number:**
Member's Phone Number:		**Requester's address:**
Member's Address:		
Diagnosis:		Requester's Fax Number: *(if applicable)*
Medication Name:		Provider's Name:
Medication Strength & Dose:		Contact Person at Provider's office:
Quantity and Day Supply:		Provider's Phone:
Length of Treatment being requested:		Provider's Fax:
Clinical Reason for Appeal (include medical documentation)		
History/Allergies		

☐ **REQUEST FOR EXPEDITED REVIEW (72 HOURS)**
BY CHECKING THIS BOX, THE PRESCRIBING PROVIDER INDICATED ABOVE OR PROVIDER'S AGENT CERTIFIES THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.

Information on this form is protected health information and subject to all privacy and security regulation under HIPAA.