FIDELIS CARE®

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Outpatient Authorization Request Form

*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 1-888-453-2534.

Fax completed form to: 1-855-776-9464

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

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

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

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

DIAGNOSIS CODES*			
ICD-10:	ICD-10:	ICD:10	ICD:10

REQUESTED SERVICES

☐Dialysis ☐Lab ☐Office visit/Procedure ☐Radiation Therapy ☐MRI ☐Sleep Study ☐X-rays ☐CT Scan

Place of Service (check one): ☐ Office (11) ☐ Outpatient Hospital (22) ☐ Dialysis Center (65) ☐ Lab (81)

Anticipated Service Date*: ___/___ /_____

PROCEDURE CODE(S)*	Description	PROCEDURE CODE(S)*	Description
CPT Code:		CPT Code:	
CPT Code:		CPT Code:	
CPT Code:		CPT Code:	

Some services may be delegated to Evicore, please check the QRG