



Prior Authorization Request

Clinical information and supportive documentation should consist of current physician order, notes and recent diagnostics. **Notification is required for any date of service change.**

Date:	Requesting Provider:		
NPI:	TIN:		
Contact Name:	Phone:	Fax:	

Type of Request

Urgent (*Urgent is defined as 'significant impact to health of member'*)

Non-Urgent Pre-Service Post-Service (Retro) Concurrent Emergent

Member Information

Member Name:	Medicaid ID:	Fidelis Care ID:	
Address:	City:	State:	ZIP Code:
Date of Birth:	Is the member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Member's PCP:	Phone:	NPI:	

Treating/Service Provider Information Same as Requesting Provider

Provider Name:	Fidelis Care ID:	NPI:	Tax ID:
Address:	City:	State:	ZIP Code:
Are any supporting documents included? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of documents: _____	Phone:	Fax:	

Treating/Service Provider Information Same as Requesting Provider

Provider Name:	Fidelis Care ID:	NPI:	Tax ID:
Address:	City:	State:	ZIP Code:
Are any supporting documents included? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of documents: _____	Phone:	Fax:	

Facility/Ancillary Information Same as Requesting Provider

Facility/Ancillary Name:	Fidelis Care ID:	NPI:	Tax ID:
Address:	City:	State:	ZIP Code:
Are any supporting documents included? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of documents: _____	Phone:	Fax:	

(continued)

Type of Service

BEHAVIORAL HEALTH SERVICES

Behavioral Health – Inpatient
 Behavioral Health – Detox
 Acute Partial Hospitalization
 Partial Hospitalization
 Behavioral Health – Partial Care
 Behavioral Health – Routine Outpatient
 Behavioral Health – AMHR Rehabilitation
 (Group Home)
 Behavioral Health – ECT
 Behavioral Health – TMS
 Other: _____

MEDICAL SERVICES

DME Purchase
 DME Rental
 Home Health
 Inpatient Admission
 Inpatient Rehab
 LTACH
 Skilled Therapy (PT/OT/ST)
 SNF
 Surgery
 Outpatient
 Surgery – Pre-Planned Inpatient
 Other: _____

TRANSPORTATION

Air
 Land
 Mileage: _____
 Trips: _____
 O2 Needed: Yes
 No

Pick Up Address (Street, City, State, ZIP Code):

Drop Off Address (Street, City, State, ZIP Code):

Place of Service

11 – Office
 12 – Home
 21 – Inpatient
 22 – Outpatient
 24 – Ambulatory Surgery Center
 41 – Land Ambulance
 41 – Air Ambulance
 51 – Inpatient Psychiatric Hospital
 53 – Community Mental Health Center
 Other: _____

Clinical Information

Request MUST include medical documentation to be reviewed for medical necessity.

ICD-10:		ICD-10:	ICD-10:	ICD-10:
Dates of Service		Procedure/Service Codes	Description	Requested Units/Visits/Days (please specify)
Start	Projected End Date			

Fidelis Care Medicaid Prior Authorization Phone Numbers

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**.

Department	Phone	Fax
All Medical	1-888-453-2534	Inpatient: 1-888-339-6339 Outpatient: 1-888-342-6548
Behavioral Health	1-888-453-2534	Inpatient: 1-855-703-8082 Outpatient: 1-888-339-2677