FHS
FIDUCIARY HEALTH SOLUTIONS

FHS PREAUTHORIZATION REQUEST FORM

** Please be advised that FHS requires seven to ten business days to response to preauthorization requests

PATIENT INFORMATION	
Name (Last, First M.):	**Date of Birth:**
Address:	**Phone:**
Identification Number:	**Name of Health Plan:**
FHS Reference Number (if you do not have one leave blank):	

PROVIDER INFORMATION	
Physician Name:	**Provider NPI:**
Facility Name:	
Facility Address:	

REQUESTER INFORMATION	
Requester Name:	**Requester Title:**
Requester Phone:	**Requester Fax:**
Requester Email:	**Date Request Submitted:**

SERVICE INFORMATION						
Name of Service	**CPT Code**	**ICD Code**	**Inpatient/ Outpatient/ In Office**	**Confirmed Date of Service**	**OR, Date Range for Services**	**Number of Visits/Length of Stay**

WHERE SERVICES WILL BE PERFORMED	
Name of Facility/Clinic	**NPI/ Tax ID**

CASE MANAGEMENT (Inpatient Only)	
Case Manager Name:	**Phone:**

Please complete and return with ***any and all*** supporting clinical documentation to
Fax: (405) 592-6215 **or** **requests@fhs.group.**

IMPORTANT NOTICE

This request, and any subsequent approval for medical necessity is **not a guarantee of payment**. All claims are subject to the terms and conditions, limitations, and exclusions of the plan in effect at the time services are rendered.