FHS
FIDUCIARY HEALTH SOLUTIONS

FHS PREAUTHORIZATION REQUEST FORM

PLEASE BE ADVISED THAT FHS REQUIRES AT LEAST SEVEN TO TEN BUSINESS DAYS TO RESPOND 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**	**Outpatient/ Inpatient (O or I)**	**Scheduled Date of Service**	**Number of Visits/Days (if more than 1 day provide date range**)**	**Date Range** Services will be Provided**

WHERE SERVICES WILL BE PERFORMED	
Name of Facility	**Facility Tax ID**

Additional Information:

- Office notes/Consultation records/OP Report
- Imaging reports
- Most recent medical records

Included	Not Included
☐	☐
☐	☐
☐	☐

Please complete and return with any 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.