Home Health Care (HHC) Request

Form Must Be Filled Out Completely And Legibly

Completion and Submission of document required for: NYS of Health, Managed Medicaid, CHP, FHP and Medicare Advantage

Fax: (877) 433-7085 **Questions:** 888-343-3547

Patient / Member Information		
Fidelis Care Member Name(Last, First, M.I.):	Fidelis Care Member ID #:	Date of Birth(mm/dd/yyyy):

Provider Information		
Name/Title:	Address(City, State, Zip):	Phone # (include area code):
Provider Tax ID #:	Provider (NPI) #:	Fax # (include area code):
IPA Affiliation (if applicable):		

HHC Services	
ICD 9 Code(s) and descriptions:	CPT/HCPCS Code(s) and descriptions:
# of Visits requested:	All prior visits used?(circle) YES NO If NO, how many remain?
Previous treatment for Dx:	Last treatment date(mm/dd/yyyy):
Quantity:	Length of Service:
Supplies:	

Additional Services (circle all applicable):

PT	HHA
OT	MSW
SP	Nutritionist

- **This form is to be filled out in its entirety for Initial/Concurrent requests; please fax to 1-877-433-7085. You will be notified of the service determination within three (3) business days for initial requests, and one (1) business day for concurrent requests.**
- **All requests for services require additional clinical to support the requested service(s) including but not limited to: History & Physical, previous diagnostic tests, and consultation reports.**
- **For continued services, please fax supporting clinical information to include the number of additional visits, date of last visit, and progress report to 1-877-433-7085. You will be notified of the medical-necessity review decision within one (1) business day.**
- **Confirmation and/or authorization do not guarantee that benefits will be paid. Payment of claims is subject to member eligibility.**