FIDELIS CARE APPEAL REQUEST FORM
FOR DENIAL OF SERVICES

Mail to:
Fidelis Care Medical Appeals Unit
P.O. Box 1208
Amherst, NY 14226

Fax to: 1-718-393-6779

Today's date: _____

Deadline: If you want a Plan Appeal, you must ask for it on time. You have 60 days from the date of this notice to ask for a Plan Appeal. The last day to ask for a Plan Appeal about this decision is

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Enrollee Information
Name:
Enrollee ID:
Address:
Home Phone: Cell Phone:
Plan Reference Number:

Service being Denied: intracept Procedure

I think the plan's decision is wrong because:

Check all that apply.

- ☐ I request a Fast Track Appeal because a delay could harm my health
- ☐ I enclosed additional documents for review during the appeal.
- ☐ I would like to give information in person
- ☐ I want someone to ask for a Plan Appeal for me:
  - Have you authorized this person with Fidelis Care before? YES ☐ NO ☐
  - Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind. ES ☐ NO ☐

Requester (person asking for me)

Name: _____ E-mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (____) _____ Fax # (____) _____

Enrollee Signature: _____ Date: _____

Requester Signature _____ Date: _____

If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to app