

Authorization Request Form

Date: _____

This request will be treated as per the standard organization determination timeframes. **If the request needs to be treated as expedited, please provide justification** that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function:

Patient Name:		DOB:	
Member ID#:		Member Phone #:	
Member Address:		City:	State: Zip:
Referral Type:			
<input type="checkbox"/> Inpatient Admit	<input type="checkbox"/> Outpatient Surgery	<input type="checkbox"/> Home Health (SN/ST/PT/OT)	<input type="checkbox"/> DME <input type="checkbox"/> OP Therapy (ST/PT/OT)
<input type="checkbox"/> Office Visit	<input type="checkbox"/> Observation	<input type="checkbox"/> Other:	
Diagnostic Procedure/Testing:			
Requesting Physician:		WellCare Provider ID#:	
Address:		City:	State: Zip:
Phone #:		Fax #:	
Contact Person:			
Treating Provider/Facility:		WellCare Provider ID#:	Phone #:
Fax #	Address:	City/State:	Zip:
If Referring Out-of-Network Please State Reason:			
Requested Procedure Description:			
CPT Code:		Requested Procedure/Admit Date:	
Additional Procedure(s):		CPT Code(s):	
Primary Diagnosis		Date of Last Office Visit:	
Secondary Diagnosis(es):			
Primary Diagnosis/Rule Out:		ICD – 10 Code:	
Secondary Diagnosis(es):		ICD – 10 Code(s):	

****PLEASE INCLUDE CLINICAL DOCUMENTATION WITH REQUEST****

ALL REFERRALS FOR HMO PLAN MEMBERS MUST BE MADE TO CONTRACTED PROVIDERS

ALL LABWORK MUST BE SENT TO: Quest Diagnostics or other in-network lab provider.

Send Claims to: SelectCare of Texas, P.O. Box 17900, Austin, TX 78760-7900

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