WellCare Health Plans, Inc.
The WellCare Group of Companies
WELLCARE OF FLORIDA, INC. ♦ HEALTHEASE OF FLORIDA, INC. ♦ WELLCARE OF NEW YORK, INC
FIRSTCHOICE HEALTHPLANS OF CONNECTICUT, INC. ♦ HARMONY BEHAVIORAL HEALTH, INC.

Notification/Authorization Form
(Medicare Only)

Failure to provide fax number will delay processing of request.

Please send the requested information by fax.

Fax #:							
FL:	877-431-8860 (Inpatient requests)	NY:	877-431-8860 (Inpatient requests)	LA:	877-431-8860 (Inpatient requests)		
FL:	800-935-5752 (outpatient requests)	NY:	800-246-7983 (outpatient requests)	LA:	877-766-3131 (outpatient requests)		
IN:	877-431-8860 (Inpatient requests)	IL:	877-431-8860 (Inpatient requests)	CT:	866-455-6529 (CMR Inpatient requests)	203-239-0016 (CMD Inpatient requests)	
IN:	866-204-6392 (outpatient requests)	IL:	866-867-9953 (outpatient requests)	CT	800-246-7983 (outpatient requests)		

Request Type: ❍ Routine ❍ Stat ❍ Expedited

- Refer to Quick Reference Guide to determine which services require authorization versus notification.
- If request is notification, you will not receive an authorization confirmation number. You may want to send a copy of your written request with the patient to the specialist.
- The authorization is valid for up to 3 visits or 60 days unless otherwise specified.
- Routine participating office labs, PCP visits, plain X-rays, immunizations and EKGs do not require notification or authorization.

Fill in the following for both notification and authorization: Request Date: ____________

Member Information:

Last: ____________ First: ____________ Member I.D: ____________ DOB: ____________

Requesting Provider Information:

PCP Last: ____________ PCP First: ____________ PCP Fax #: ____________

Rendering Provider Information:

Provider ID #: ____________ Provider phone #: ____________ Provider Fax #: ____________
Specialist Name: ____________ Specialist Address: ____________
Facility Name: ____________ Facility Address: ____________
Facility Type:
❍ Inpatient Hospital
❍ Outpatient Hospital
❍ Freestanding Outpatient or Facility
❍ 23-Hour Observation

Clinical Information:

ICD-9 ____________ Diagnosis Description: ____________

CPT Code(s): ____________ CPT Description: ____________

Authorization: Indications for surgery/procedure (please attach consultation notes and/or progress report):

____
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For Notification Only: *(check boxes that apply)*

❍ Specialist consultation with/without treatment
❍ Physical Therapy (Initial 3 visits)
❍ Speech Therapy (Initial 3 visits)
❍ Occupational Therapy (Initial 3 visits)

M.D. / D.O. Signature ____________ Date ____________

Note: *Authorization will be given for medically necessary services only; it is not a guarantee of payment. Eligibility will be authenticated prior to payment. Payment is subject to verification of eligibility and to the limitations and exclusions of the member's contract.*