



Providing Inpatient Notification or Requesting an Authorization for WellCare Medicare Members

WellCare requests to be notified of all inpatient hospital admissions, observations, and the first outpatient dialysis visit. Notification allows for timely and effective discharge planning as well as the identification of patients in need of case management.

To determine the need for an authorization from WellCare and the type of request to submit, a provider should refer to the Quick Reference Guide.

Requesting an Authorization for Planned Services

Requests for standard authorizations must be submitted at least 14 calendar days prior to planned services. WellCare is committed to a **48-hour turn-around** time on prior authorization requests.

You can request authorization in one of three ways:

1

Online

OR

2

By Fax

OR

3

By Phone

1. Log onto www.wellcare.com, if you are a registered user. (If not a registered user, select "Not Registered? Sign Up Today!" and complete the online registration process).
2. Once you are logged on, click on [Authorization/Certification](#) under [Submissions](#).
3. Enter your name and Provider ID number and follow the prompts.

1. Complete the appropriate WellCare notification or authorization form for the type of care needed. Forms can be found online at www.wellcare.com, in Provider Resources area. You may also contact your Provider Relations representative to obtain a copy.
2. Complete every section of the form to prevent any delays in processing.
3. **Fax the form** and include any supporting documentation, if less than 10 pages.

Inpatient/Observation notification forms:
(877) 431-8860.

Outpatient (dialysis) notification forms:
(877) 892-8213.

EMERGENT OR URGENT AUTHORIZATIONS ONLY

Call the **Provider Hotline at (866) 334-7730**. A representative will request the following:

- Member name and ID number
- Provider ID and NPI number or name of the treating physician
- Facility ID and NPI number or name where services will be rendered (when appropriate)

You will also be asked for information on planned services including:

- Date(s) of Service
- Diagnosis and Diagnostic codes
- CPT codes

Please see the WellCare Provider Manual for additional information. Visit our Web site at www.wellcare.com for regular updates.





Notification/Authorization for Urgent or Emergent Services

Call the **Utilization Management Department at (866) 334-7730**.

Urgent or emergent authorization requests may be submitted to WellCare for expedited determination when following the standard timeframe could seriously jeopardize the member's life or health. Requests for expedited authorizations will receive a determination within 24 hours.

Notification/Authorization Guidelines

- **Refer to the Quick Reference Guide** – and/or the Provider Manual to ensure proper authorization or notification requirements.
- **List the related CPT Code(s)** – CPT codes must be included with authorization requests and claims submissions when applicable.
- **Include your fax number** – on the form submitted to ensure a prompt response to your authorization request.
- **Facility fax number** – WellCare will fax authorizations to the treating facility when this is specified on the authorization request and the facility's fax number is provided on the authorization form.
- **Consider timing** – WellCare is committed to respond to faxed requests for prior authorization in approximately 48 hours. However, by contract, the plan has up to 14 calendar days following the request to complete authorization determinations for non-urgent services.
- **Authorization date** – Authorizations are valid for the time noted on each WellCare authorization response.
- **Authorizations for multiple visits** – WellCare may grant multiple visits under one authorization when a plan of care shows medical necessity for this request.
- **Be sure to know when to request an authorization** – Failure to obtain the necessary prior authorization from WellCare could result in a denied claim.

▷ *Authorization does not guarantee payment. All services or procedures are subject to benefit coverage, limitations and exclusions as described in applicable plan coverage guidelines.*