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Surgery Prior Authorization Form

*Indicates a required field

Requirements: Clinical information and supportive documentation should consist of current physician order, notes and recent diagnostics. **Notification is required for any date of service change.** **Expedited Requests:** If the standard time for making a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call

Fax completed form for WellCare Value (HMO) to: 1-855-754-8483

Fax completed form for WellCare Patriot (PPO) to: 1-866-246-9832

Requestor Name: _____ Fax*: _____ Phone*: _____

MEMBER INFO (Please Print)			
WellCare ID*:		Medicaid/Medicare ID:	
Last Name*:	First Name, MI*:	Date of Birth*: / /	
REQUESTING PROVIDER (Please Print)			
WellCare ID:		NPI/Tax ID*:	
Provider Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:
FACILITY (Please Print)			
WellCare ID:		NPI/Tax ID:	
Facility Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:
PHYSICIAN (SURGEON)			
WellCare ID:		NPI/Tax ID*:	
Provider Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:
DIAGNOSIS CODES*			
ICD-10:	ICD-10:	ICD-10	ICD-10
Place of Service (check one): <input type="checkbox"/> Office (11) <input type="checkbox"/> Inpatient Hospital (21) <input type="checkbox"/> Outpatient Hospital (22) <input type="checkbox"/> Ambulatory Surgery Center (24)			
Planned/Anticipated Surgery Date*: ___/___/___			
PROCEDURE CODE(S)*	Description	PROCEDURE CODE(S)*	Description
CPT Code:		CPT Code:	
CPT Code:		CPT Code:	
CPT Code:		CPT Code:	

Include all supporting clinicals and additional codes if needed