WellCare
Beyond Healthcare. A Better You.

FL Long Term Care Authorization Form

Medicaid Fax To**: 1-877-431-8860**
Medicare Fax to**: 1-855-776-9464**
Self-service options: www.WellCare.com

Requestor Name: _____Faxback No.: _____Phone No.: _____
This request will be treated as per the standard organization determination time frames. **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: _____
_____

MEMBER INFO		
WellCare ID:	**Last Name:**	**First Name, MI:**
Medicaid/Medicare ID:	**Phone No.:**	**Date of Birth:_____/_____/_____**

REQUESTING PROVIDER		
WellCare ID:	**Provider/Facility Name:**	
Address:	**City, State, ZIP:**	
Phone No.:	**Faxback No.:**	**NPI/Tax ID No.:**

TREATING PROVIDER		
WellCare ID:	**Provider/Facility Name:**	
Address:	**City, State, ZIP:**	
Phone No.:	**Faxback No.:**	**NPI/Tax ID No.:**

SERVICING FACILITY		
WellCare ID:	**Provider/Facility Name:**	
Address:	**City, State, ZIP:**	
Phone No.:	**Faxback No.:**	**NPI/Tax ID No.:**

REQUIRED DATES
****Facility is responsible to start and complete the below requirements. These are not a guarantee of payment, but is dependent on member eligibility and submission of required forms****

Custodial Bed Admission Date _____/_____/_____	
LTC Approval Date: _____/_____/_____	**LTC Effective Date: _____/_____/_____**
Level 1 PASSR Completion Date:_____/_____/_____	**CF-ES-2506A Submission Date:_____/_____/_____**
Level 2 PASSR Completion Date:_____/_____/_____	**CARES LOC Assessment Date :_____/_____/_____**
ICP Application Start Date:_____/_____/_____	**ICP Approval Date:_____/_____/_____**
Primary **ICD-10** Code:	**Diagnosis Description:**

****PLEASE INCLUDE ALL CLINICALS WITH REQUESTS****

Staywell℠
A WellCare Company

©WellCare 2019