

Inpatient Authorization Request



FAX TO: MEDICARE

All States Medicare: Fax 1-855-776-9464

Requestor's Name:	Fax:	Phone:	Ext.
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MEMBER

WellCare ID:	Last Name:	First Name, MI:
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Medicaid/Medicare #:	Phone Number:	Date of Birth:
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REQUESTING PROVIDER

WellCare ID :	Provider/Facility Name:
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Address:	City, State, ZIP
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Phone:	Fax:	NPI/Tax ID:
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SERVICING FACILITY

WellCare ID:	NPI/Tax ID:
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Facility Name:	Phone Number	Fax Number
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Address	City, State, ZIP
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SERVICING PROVIDER

WellCare ID:	NPI/Tax ID:
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Facility Name:	Phone Number	Fax Number
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Address	City, State, ZIP
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ADMISSION INFO

Preplanned Admission Emergency Room Visit Observation Inpatient Admit LTACH SNF

Place of Service: 21 Inpatient Hospital 22 Outpatient Hospital 23 ER Hospital 31 Skilled Nursing Facility

Admission Date or Planned Admission Date: ___/___/___ **Requested length of stay:** ___ days

Primary ICD-10 Code: _____ **Description:** _____

Primary CPT-4 Code : _____ **Description:** _____

Please include additional procedures codes, as applicable, in the Clinical Summary below.

Pertinent Clinical Summary: (Attach supporting clinical records, if necessary).
