

**Want faster service? Use our Provider Portal @ [provider.wellcare.com](http://provider.wellcare.com)**

## Inpatient Authorization Request Form

\*Indicates a required field

**Requirements:** *Clinical information and supporting 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 to make a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call **1-855-538-0454**.

**Fax completed form to: 1-855-776-9464.**

**Requestor Name:** \_\_\_\_\_ **Fax\*#:** \_\_\_\_\_ **Phone\*#:** \_\_\_\_\_

MEMBER INFO (Please Print)			
WellCare ID*:		Medicaid/Medicare ID:	
Last Name*:	First Name, MI*:	Date of Birth*:    /    /	
REQUESTING PROVIDER			
WellCare ID:		NPI/Tax ID*:	
Provider Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:
FACILITY (Please Print)			
WellCare ID:		NPI/Tax ID*:	
Provider/Facility Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:
ATTENDING PROVIDER (Please Print)			
WellCare ID:		NPI/Tax ID*:	
Provider/Facility Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:
DIAGNOSIS CODES*			
ICD-10:	ICD-10:	ICD-10:	ICD-10:
REQUESTED SERVICES			
<input type="checkbox"/> Observation <input type="checkbox"/> Inpatient Admission <input type="checkbox"/> LTACH <input type="checkbox"/> SNF/Sub-Acute Rehab <input type="checkbox"/> Inpatient Rehab <input type="checkbox"/> Waitlist <input type="checkbox"/> ICF <input type="checkbox"/> Other (please specify): _____			
<b>Place of Service (check one):</b> <input type="checkbox"/> ALF (13) <input type="checkbox"/> Observation Hospital (22) <input type="checkbox"/> Inpatient (21) <input type="checkbox"/> SNF (31) <input type="checkbox"/> Nursing Facility (32) <input type="checkbox"/> Custodial Care Facility (33) <input type="checkbox"/> Other (please specify): _____			
Date of Admission*: ____ / ____ / ____		Is this a Level of Care Change (OBS to INP)? <input type="checkbox"/> Yes <input type="checkbox"/> No Observation Admit Date:	
PROCEDURE CODE(S)*	Description	PROCEDURE CODE(S)	Description
CPT Code:		CPT Code:	
CPT Code:		CPT Code:	
CPT Code:		CPT Code:	