WellCare
Beyond Healthcare. A Better You.

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INPATIENT 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 1-888-453-2534.

Fax completed form to 1-888-339-6339

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:

ATTENDING PHYSICIAN (Please Print)		
WellCare ID:	NPI/Tax ID*:	
Provider Name*:	Address:	
City, State, ZIP:	Fax:	Phone:

DIAGNOSIS CODES			
ICD-10*:	ICD-10:	ICD:10	ICD:10

☐Observation ☐Inpatient Admission ☐LTACH ☐SNF/Sub-Acute Rehab ☐Inpatient Rehab ☐Waitlist ☐ICF

Date of Admission*:	Is this a Level of Care Change (OBS to INP)? Y/N Observation Admit Date:

PROCEDURE CODE(S)	DESCRIPTION
CPT/HCPC Code:	
CPT/HCPC Code:	

Some authorizations may be delegated to CareCentrix, please check the QRG