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Skilled Therapy Authorization Request

*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 1-877-709-1698

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:

SERVICING PROVIDER (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

Place of Service (check one): ☐ Office ☐ Hospital ☐ Home ☐ Other, please specify: _____

Date of last Therapy Evaluation or Re-Evaluation:	PT:	OT:	ST:

Attach a copy of the therapy evaluation/re-evaluation or progress summary (acute) for each therapy discipline requested below. **Do not use the Evaluation Date as the start date for services.**

Service Requested	Procedure Code*	Start Date*	End Date	Frequency
Physical Therapy				____ days a week for _____ weeks = _____ visits
Occupational Therapy				days a week for weeks = _____ visits
Speech Therapy				____ days a week for _____ weeks = _____ units
Other:				____ days a week for _____ weeks = _____ visits

PT and OT services may be delegated to EviCore, please check the QRG