WellCare Health Plans

Personal Care Assistant/Medical Day Care

Authorization Request Form

Fax Completed Form to: **1-855-573-2346**

Adult Request ___ Pediatric Request____ Group Request ____

Please check type of request:
Initial Request ___ Re-Assessment ___ Agency Transfer ___ MCO Transfer ___ Change Request___

Date Submitted to MCO: _____

Member Name:_____ WellCare ID#_____ DOB: _____

Member Address (Street/City) _____

Member Phone #_____Translation Needed: Yes No Language:_____

Current Authorization Expires on: _____ Current Hours Member receives _____

Has member had a lapse in Service for 30 consecutive days during prior authorization period: Yes No

Requesting Authorization from _____ to _____ Hours Requested:_____

Is member in Assisted Living: Yes / No

Primary Dx:_____ ICD Code:_____ Other Dx: _____ ICD Code:_____

Is this a group case: Yes No If yes, please provide the Name & DOB member is grouped with:

Name:_____ MBR ID:_____ DOB:_____

Please check one of the following codes:

___ PCA Services (Individual, Hourly, Weekday) - T1019
___ PCA Services (Group, Hourly, Weekday) - T1019 HQ

Change in Service Request: Increase / Decrease

Information to support service change (must provide specifics):
_____

Adult Medical Day Care (S 5102) # of days: _____ Hours per week: _____
Pediatric Medical Day (T 1024) # of days_____ Hours per week:_____
Clinical Summary: Please attach reason for medical necessity and physician/practitioner order

AgencyName:_____Provider#_____NPI#_____
Phone # of Agency: _____ Fax #:_____
Contact Person at Agency: _____