

Assisted Living Facility Authorization Request for MLTSS Members

Dear Provider:

To ensure that our members receive quality care, claims are paid appropriately, and servicing providers are notified, please complete this form in its entirety. Please type or print in black ink and submit this request to fax number on Page 2.

A. MEMBER DEMOGRAPHIC INFORMATION (* Indicates Required Fields)

WellCare ID	Last Name*	First Name*	DOB*
Home Address*:			
Home Phone #*:		Medicaid ID:	
Caregiver/POA Name*:		Caregiver/POA Phone*#:	
Additional Primary Insurance Name*:		Policy* #: Contact* #:	

B. FACILITY INFORMATION:

Name*:	WellCare Provider ID*:
	Tax ID*:
Contact Name and Phone/Fax* #:	NPI*:
Address*:	Member Medical Record #:

C. VERIFICATION INFORMATION: (*All fields are required fields)

Date request is Submitted*:	
Admission Date to Facility*:	Dx Code(s)*:
Start Date of Requested Services*:	Dx Code(s)*:

Clinical Information Needed: (Please include following with this completed authorization request form)

1. Last four weeks of clinical documentation (Examples: Nursing notes, medication list (if applicable), Name of PCP, Care Plan/Service plan and or Treating specialist)*

Please note authorization will NOT be valid until documentation has been received. *Required fields must be completed.* Please also note that the member ***must be enrolled*** in the **NJ MLTSS (Managed Long Term Support Services) program** to receive authorization for services at an Assisted Living Facility. Prior to enrollment into MLTSS, a member assessment will be completed by a Wellcare assessor and submitted for review to the NJ Office of Community Options for determination. A maintenance authorization will be granted for 6 months upon MLTSS approval and as the member continues to meet medical and eligibility criteria.

Please Submit Required Documentation to the Appropriate Market Department:

- NJ MLTSS Care Management phone: 1-855-642-6185 OPTION 2
- NJ MLTSS FAX: 1 - 855-573-2346