



# Hospice Authorization Request Form

*\*Indicates a required field*

**Requirements:** Clinical information and supporting documentation should consist of current physician orders, 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**.

 Please fax completed form to appropriate number at bottom of form.

Requestor Name*:	Fax*:	Phone*:
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## Member Information (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*:	Fax*:	Phone:
Address:	City:	State: ZIP Code:

## Hospice Provider (please print)

Wellcare ID:	NPI/Tax ID*:	
Provider/Facility Name*:	Fax*:	Phone:
Address:	City:	State: ZIP Code:

## Place of Service

Home (12)     Inpatient Hospital (21)     Hospice (34)     Other (please specify): \_\_\_\_\_

## Diagnosis Codes\*

ICD-10:	ICD-10:	ICD-10:	ICD-10:
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(continued)

## Requested Services (please choose only one)

	Requested Start Date	Requested End Date	# of Hours Request
<input type="checkbox"/> Routine Home Care T0402			
<input type="checkbox"/> General Inpatient T2045			
<input type="checkbox"/> Inpatient Respite T2044			
<input type="checkbox"/> Continuous Home Care T2043			
<input type="checkbox"/> Other Description: _____			

 Please fax completed form to:

## Medicare Fax Lines

Connecticut: <b>1-866-455-6529</b>	Kentucky: <b>1-888-361-5684</b>
Florida Medicare only: <b>1-877-892-8216</b>	New Jersey: <b>1-877-892-8221</b>
Georgia Medicare only: <b>1-877-892-8213</b>	New York: <b>1-877-892-8214</b>
Florida/Georgia Dual: <b>1-877-277-1820</b>	Texas: <b>1-877-894-2034</b>
Illinois: <b>1-877-899-2044</b>	All others: <b>1-888-361-5684</b>



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