



Inpatient 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 **1-855-776-9464**.

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:

Facility (please print)

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

Attending Provider (please print)

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

(continued)

Diagnosis Codes*

ICD-10:

ICD-10:

ICD-10:

ICD-10:

Requested Services (please choose only one)

Observation Inpatient Admission LTACH SNF/Sub-Acute Rehab Inpatient Rehab
 Waitlist ICF Other (please specify): _____

Place of Service: (check one): ALF (13) Observation Hospital (22) Inpatient (21)
 SNF (31) Nursing Facility (32)

Date of Admission*: / /

Is this a Level of Care Change (OBS to INP)?: Yes No
Observation Admit Date: / /

Procedure Code(s)*

Description

CPT Code:

CPT Code:

CPT Code:

CPT Code:

CPT Code:

CPT Code:



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