



Outpatient 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:

Servicing Provider or Facility (please print)

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

Treating 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)

Dialysis Office Visit/Procedure Radiation Therapy MRI Sleep Study X-Rays CT Scan
 Other (please specify): _____

Place of Service: (check one):

Telehealth (02) Office (11) Outpatient Hospital (22)
 Dialysis Center (65) Lab (81)

Anticipated Service Date*: / /

Procedure Code(s)*

Description

CPT Code:

CPT Code:

CPT Code:

CPT Code:

CPT Code:

CPT Code:



Please fax completed form to:

Medicare Fax Lines

Connecticut: **1-866-455-6529**

Kentucky: **1-888-361-5684**

Florida Medicare only: **1-877-892-8216**

New Jersey: **1-877-892-8221**

Georgia Medicare only: **1-877-892-8213**

New York: **1-877-892-8214**

Florida/Georgia Dual: **1-877-277-1820**

Texas: **1-877-894-2034**

Illinois: **1-877-899-2044**

All others: **1-888-361-5684**



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