Inpatient Authorization Request

FAX TO: MEDICARE		
Arizona Medicare: Fax (866) 246-9832 **All Other States Medicare: Fax** (855) 776-9464		
Requestor's Name:	**Fax:**	**Phone:** **Ext.**
MEMBER		
WellCare ID:	**Last Name:**	**First Name, MI:**
Medicaid/Medicare #:	**Phone Number:**	**Date of Birth:**
REQUESTING PROVIDER		
WellCare ID :	**Provider/Facility Name:**	
Address:	City, State, Zip	
Phone:	Fax:	NPI/Tax ID:
SERVICING FACILITY		
WellCare ID:	NPI/Tax ID:	
Facility Name:	Phone Number	Fax Number
Address	City, State, Zip	
SERVICING PROVIDER		
WellCare ID:	NPI/Tax ID:	
Facility Name:	Phone Number	Fax Number
Address	City, State, Zip	
ADMISSION INFO		
☐Preplanned Admission ☐Emergency Room Visit ☐Observation ☐Inpatient Admit ☐LTACH ☐SNF		
Place of Service: ☐21 Inpatient Hospital ☐22 Outpatient Hospital ☐23 ER Hospital ☐31 Skilled Nursing Facility		
Admission Date or Planned Admission Date: ___/___ /_____ Requested length of stay: _____ days		
Primary **ICD-10** Code: ____________ **Description**:____________________________________		
Primary **CPT-4** Code : **Description**:		
Please include additional procedure codes, as applicable, in the Clinical Summary below.		
Pertinent Clinical Summary: (Attach supporting clinical records, if necessary).		

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