WellCare®

Beyond Healthcare. A Better You.

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).			