



Outpatient Authorization Request

FAX TO: MEDICARE

Arkansas: 1-877-277-1820	Arizona: 1-866-246-9832	Connecticut: 1-877-892-8215
Florida: 1-877-892-8216	Illinois: 1-877-899-2044	Georgia: 1-877-892-8213
Kentucky: 1-888-361-5684	Louisiana: 1-866-455-6488	Mississippi: 1-877-277-1820
New Jersey: 1-877-892-8221	New York: 1-800-246-7983	South Carolina: 1-877-277-1820
Tennessee: 1-877-277-1820	Texas: 1-877-894-2034	

PRIORITY LEVEL

Standard Post Service

*For an urgent request call **1-800-351-8777**

Requestor's Name:	Fax:	Phone:	Ext.:
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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:	

REQUESTED SERVICES

Ambulatory Surgery Dialysis Lab Office visit/procedure Outpatient Hospital Radiation Therapy

Place of Service: 11 Office 22 Outpatient Hospital 24 Ambulatory Surgery 81 Independent Lab

Date of Service ___/___/____

Primary ICD-10 Code: **Description:**

Primary CPT-4 Code : **Description:**

Please include additional procedures codes, as applicable, in the Clinical Summary below.

Pertinent Clinical Summary: (Attach supporting clinical records, if necessary).