Inpatient Authorization Request

WellCare
Beyond Healthcare. A Better You.

FAX TO:			
Florida Medicaid: Fax 1-877-431-8860			
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

****For an urgent request call 1-800-351-8777. Do not use this form****

☐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 procedures codes, as applicable, in the Clinical Summary below.

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

Authorizations will be given for medically necessary services only: it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergencies do not require prior authorization (An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result, without immediate medical attention, in serious jeopardy to the health of an individual). *Urgent Care is defined as medically necessary treatment for an injury, illness, or other type of condition (usually not life threatening) which should be treated within 24 hours.

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