

Authorization Request Form

For self-service options: Visit the Web @ www.WellCare.com

Requestor Name: _____ **Fax:** _____ **Phone** _____

This request will be treated as per the standard organization determination time frames. **If the request needs to be treated as expedited, please provide justification** that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function: _____

MEMBER INFO			
WellCare ID:	Last Name:	First Name, MI:	
Medicaid/Medicare ID:	Phone No.:	Date of Birth: / /	
REQUESTING PROVIDER			
WellCare ID:	Provider/Facility Name:		
Address:		City, State, ZIP:	
Phone No.:	Fax No.:	NPI/Tax ID:	
TREATING PROVIDER			
WellCare ID:	Provider/Facility Name:		
Address:		City, State, ZIP:	
Phone No.:	Fax No.:	NPI/Tax ID:	
SERVICING FACILITY			
WellCare ID:	Provider/Facility Name:		
Address:		City, State, ZIP:	
Phone No.:	Fax No.:	NPI/Tax ID:	
REQUESTED SERVICE			
<input type="checkbox"/> Inpatient <input type="checkbox"/> Observation <input type="checkbox"/> SNF <input type="checkbox"/> DME <input type="checkbox"/> Skilled Therapy (PT/OT/ST) <input type="checkbox"/> Outpatient Surgery <input type="checkbox"/> Home Health <input type="checkbox"/> Other: _____ Place of Service: _____			
Admit/Start Date: ___ / ___ / ___		Days Requested: _____	
Primary ICD-10 Code:		Description:	
Primary CPT-4 Code:		Description:	Units/Visits:
Additional Codes:			

****PLEASE INCLUDE CLINICAL DOCUMENTATION WITH REQUEST****

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