WellCare®
Beyond Healthcare. A Better You.

Children's Medical Services Health Plan
Inpatient: 877-431-8860
Outpatient: 800-935-5752
Home Health & DME: 855-657-8641

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		
☐ **Inpatient** ☐ **Observation** ☐ **SNF** ☐ **DME** ☐ **Skilled Therapy (PT/OT/ST)** ☐ **Outpatient Surgery** ☐ **Home Health** ☐ **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****