WellCare
Beyond Healthcare. A Better You.

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Hospice Auth Request Form

*Indicates a required field

Requirements: *Clinical information and supportive documentation should consist of current physician order, notes and recent diagnostics. Notification is required for any date of service change.* ***Expedited Requests:*** If the standard time for making a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call **1-855-538-0454**

For Medicare ONLY Members, fax form to: (877) 892-8213
For Dual Eligible Members (members with Medicare and Medicaid policies), fax form to: (855) 292-0233

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

WellCare ID*:	Medicaid/Medicare ID:	First Name, MI*:
Last Name*:	First Name, MI*:	Date of Birth*: / /

WellCare ID:	NPI/Tax ID*:	
Provider Name*:	Address:	
City, State, ZIP:	Fax*:	Phone:

HOSPICE PROVIDER

WellCare ID:	NPI/Tax ID*:	
Provider Name*:	Address:	
City, State, ZIP:	Fax*:	Phone:

DIAGNOSIS CODES*

ICD-10:	ICD-10:	ICD:10	ICD:10

REQUESTED HOSPICE SERVICES*

	Requested Start Date	Requested End Date	
☐ Routine Home Care T2042			# of Hours Requested:
☐ General Inpatient T2045			
☐ Inpatient Respite T2044			
☐ Continuous Home CareT2043			
☐ Other: Description:			