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## INPATIENT AUTHORIZATION 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\*: \_\_\_\_\_

MEMBER INFO (Please Print)			
WellCare ID*:		Medicaid/Medicare ID:	
Last Name*:	First Name, MI*:	Date of Birth*:    /    /	
REQUESTING PROVIDER (Please Print)			
WellCare ID:		NPI/Tax ID*:	
Provider Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:
FACILITY (Please Print)			
WellCare ID:		NPI/Tax ID*:	
Facility Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:
ATTENDING PHYSICIAN (Please Print)			
WellCare ID:		NPI/Tax ID*:	
Provider Name*:		Address:	
City, State, ZIP:		Fax:	Phone:
DIAGNOSIS CODES			
ICD-10*:	ICD-10:	ICD:10	ICD:10
<input type="checkbox"/> Observation <input type="checkbox"/> Inpatient Admission <input type="checkbox"/> LTACH <input type="checkbox"/> SNF/Sub-Acute Rehab <input type="checkbox"/> Inpatient Rehab <input type="checkbox"/> Waitlist <input type="checkbox"/> ICF			
Date of Admission*:		Is this a Level of Care Change (OBS to INP)? Y / N    Observation Admit Date:	
PROCEDURE CODE(S)		DESCRIPTION	
CPT/HCPC Code:			
CPT/HCPC Code:			

\*\*Some authorizations may be delegated to CareCentrix, please check the ORG\*\*