WellCare
Beyond Healthcare. A Better You.

Want faster service? Use our Provider Portal @ Provider.WellCare.com

Outpatient Authorization 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*: _____

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:

SERVICING PROVIDER OR FACILITY (Please Print)		
WellCare ID:	NPI/Tax ID*:	
Provider/Facility Name*:	Address:	
City, State, ZIP:	Fax*:	Phone:

DIAGNOSIS CODES*			
ICD-10:	ICD-10:	ICD:10	ICD:10

REQUESTED SERVICES
☐ Dialysis ☐ Lab ☐ Office visit/Procedure ☐ Radiation Therapy ☐ MRI ☐ Sleep Study ☐ X-rays ☐ CT Scan
Place of Service (check one): ☐ Office (11) ☐ Outpatient Hospital (22) ☐ Dialysis Center (65) ☐ Lab (81)
Anticipated Service Date*: ___/___/_____

PROCEDURE CODE(S)*	Description	PROCEDURE CODE(S)*	Description
CPT Code:		CPT Code:	
CPT Code:		CPT Code:	
CPT Code:		CPT Code:	

Some services may be delegated to Evicore, please check the QRG