

# Transplant Authorization Request



**FAX TO: (813)283-5320**

**Save time! Submit and review your requests online @ <https://provider.wellcare.com>**

<b>Requestor's Name:</b>		<b>Fax:</b>	<b>Phone:</b>	<b>Ext.</b>
<b>MEMBER</b>				
<b>WellCare ID:</b>	<b>Last Name:</b>		<b>First Name, MI:</b>	
<b>Medicaid/Medicare #:</b>	<b>Phone Number:</b>		<b>Date of Birth:</b>	
<b>REQUESTING PROVIDER</b>				
<b>WellCare ID :</b>	<b>Provider/Facility Name:</b>			
<b>Address:</b>	<b>City, State, Zip:</b>			
<b>Phone:</b>	<b>Fax:</b>	<b>NPI/Tax ID:</b>		
<b>SERVICING FACILITY</b>				
<b>WellCare ID:</b>	<b>NPI/Tax ID:</b>			
<b>Facility Name:</b>	<b>Phone Number:</b>		<b>Fax Number:</b>	
<b>Address:</b>	<b>City, State, Zip:</b>			
<b>TREATING PROVIDER</b>				
<b>WellCare ID:</b>	<b>NPI/Tax ID:</b>			
<b>Treating Provider Name:</b>	<b>Phone Number:</b>		<b>Fax Number:</b>	
<b>Address:</b>	<b>City, State, Zip:</b>			
<b>TRANSPLANT INFO</b>				
Global Surgery: <input type="checkbox"/> Transplant Consultation <input type="checkbox"/> Transplant Evaluation <input type="checkbox"/> Transplant Listing <input type="checkbox"/> Actual Transplant				
<b>Transplant Type:</b> <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Solid Organ <input type="checkbox"/> Islet Cell <input type="checkbox"/> Stem Cell: Allogeneic / Autologous (Circle One)				
<b>Solid Organ Type:</b>				
Place of Service: <input type="checkbox"/> 11 Office <input type="checkbox"/> 19 Off-Campus OPH <input type="checkbox"/> 21 Inpatient Hospital <input type="checkbox"/> 22 On Campus-OPH <input type="checkbox"/> 24 Ambulatory Surgery Center				
<b>Planned Service/Admission Date:</b> ___/___/___			<b>Requested length of stay:</b> ___ days	
<b>Primary ICD-10 Code:</b> _____ <b>Description:</b> _____				
<b>Primary CPT-4 Code:</b>				
<b>Description:</b>				
Please include additional procedures codes, as applicable, in the Clinical Summary below.				
<b>Pertinent Clinical Summary:</b> (Attach supporting clinical records, if necessary).				