# Outpatient Authorization Request Form Without Transportation

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

**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: **Medicare** 1-888-505-1201/**Medicaid** 1-888-846-4262.

**Fax completed form to**: 888-881-8225
***Indicates a required field**

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

| ***MEMBER INFO (Please Print)*** | | |
|---|---|---|
| ***Ohana 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***

☐Pre-planned Inpatient ☐Ambulatory Surgery ☐Office visit/Procedure ☐Home Health ☐ Other:_____

***Anticipated Service Date*:*** ___/___/_____ *to* ___/___/_____

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