missouricare
A WellCare Company

Authorization Exceptions Request

Phone: 800-322-6027 / Fax: 866-946-2052

Member information

MEMBER'S NAME: Last:	First:	MI:

DCN:	DOB:	TODAY'S DATE:

OTHER INSURANCE CARRIER: (IF APPLICABLE)	POLICY #: (IF KNOWN)	MEMBER'S PHONE #:

Is a home health agency making skilled nurse visits?
- ☐ yes
- ☐ no

If so, agency name:	Agency phone number:

Member's ICD-10 dx codes: (must be related to the service or items requested)

List all appropriate alternative covered services attempted and found ineffective for the above diagnosis:

CPT CODE: (Required)	Place of Service:	Description:	Number of units: (including daily quantity)	Duration of need

Servicing provider (provider who will dispense and bill for services)

Provider name:

Address:

Provider phone:	Provider fax:

Servicing Provider ID#:	TIN #:	NPI #:

Referring provider

Referring provider name:	Referring provider address:

Referring Provider ID#:	TIN #:	NPI #:

Contact person's name:	Contact phone number:	Contact fax number:

Doctor's original signature(no stamps or photocopies)

***ALL CLINICAL INFORMATION TO SUPPORT REQUESTED SERVICES IS REQUIRED TO BE SUBMITTED WITH THIS FORM**

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