Home Health Services Authorization Request

FL MEDICAID AND FL MEDICARE FAX TO: (855)-657-8641 KENTUCKY MEDICAID FAX TO: (855)-620-1871
ALL OTHER STATES FAX TO: (866)886-4321

CHOOSE THE APPROPRIATE REQUEST TYPE

☐ **Initial Request** ☐ **Continuation of Services**

Do not use this form for an urgent request, call (800) 351-8777

MEMBER INFORMATION

WellCare ID:	**Last Name:**	**First Name, MI:**
Medicaid/Medicare #:	**Phone Number:**	**Date of Birth:**

ORDERING PROVIDER INFORMATION

WellCare ID Number:	**NPI Number:**	
Last Name:	**First Name:**	
Street Address:	**City, State:**	**Zip Code:**
Phone Number:	**Fax Number:**	
Provider Type/Specialty:	**Name of Requester:**	

TREATING PROVIDER / VENDOR

Place of Service: ☐**Office** ☐ **Clinic** ☐ **Outpatient Hospital** ☐ **Home Health Agency** ☐ **Hospice** ☐ **Other:**

WellCare ID Number:	**NPI Number:**	
Last Name:	**First Name:**	
Street Address:	**City, State:**	**Zip Code:**
Phone Number:	**Fax Number:**	
Provider Type/Specialty:	**Name of Requester:**	

REQUESTED SERVICES

Requested Dates of Service: From: To:	**Previous Authorization # (if continuation):**
Original Start Date of Care:	**Number of Visits Rendered to Date:**

INSTRUCTIONS: Select the Discipline Requested and Enter the Quantity of Visits Needed.

☐ **Skilled Nursing**	Times per week for weeks	☐ **Home Health Aid**	Times per week for weeks
☐ **Occupational Therapy**	Times per week for weeks	☐ **Physical Therapy**	Times per week for weeks
☐ **Speech Therapy**	Times per week for weeks	☐ **Medical Social Worker**	Times per week for weeks

Primary ICD-9 Codes(s):	**Description / Condition:**
Secondary ICD-9 Codes(s):	**Description / Condition:**
CPT/HCPC Code:	**Description / Service:**
CPT/HCPC Code:	**Description / Service:**
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****Note**: Nursing visits related to Infusion Therapy or Enteral Nutrition should be faxed to the WellCare Pharmacy Department for review. Please refer to your state specific Quick Reference Guide for forms and fax numbers.

****Note**: Requests for Medical Supplies not related to the Plan of Care Should be faxed to our Durable Medical Equipment (DME) Dept. for review. Please refer to your state specific Quick Reference Guide for appropriate fax numbers and website address.

*Authorizations will be given for medically necessary services only: it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergencies do not require prior authorization (An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result, without immediate medical attention, in serious jeopardy to the health of an individual). *Urgent Care is defined as medically necessary treatment for an injury, illness, or other type of condition (usually not life threatening) which should be treated within 24 hours.*