## Inpatient Authorization Request



Facility Name:  Address  City, State, ZIP  SERVICING PROVIDER  WellCare ID:  NPI/Tax ID:  Facility Name:  Phone Number  Fax Number  Fax Number	FAX TO: MEDICARE					
WellCare ID: Last Name: Phone Number: Date of Birth:  REQUESTING PROVIDER  WellCare ID: Provider/Facility Name: Address: City, State, ZIP Phone: Fax: NPI/Tax ID: SERVICING FACILITY WellCare ID: NPI/Tax ID: Facility Name: Address City, State, ZIP Phone Number Fax Number Address City, State, ZIP  WellCare ID: NPI/Tax ID: Facility Name: Phone Number Fax Number Address City, State, ZIP  SERVICING PROVIDER  WellCare ID: Facility Name: City, State, ZIP  SERVICING PROVIDER  WellCare ID: Facility Name: Phone Number Fax Number  Address City, State, ZIP  ADMISSION INFO Preplanned Admission   Emergency Room Visit   Observation   Inpatient Admit   LTACH   SNF Place of Service:   21 Inpatient Hospital   22 Outpatient Hospital   23 ER Hospital   31 Skilled Nursing Facility  Admission Date or Planned Admission Date:  /	All States Medicare: Fax 1-855-776-9464					
Medicaid/Medicare #: Phone Number: Date of Birth:    REQUESTING PROVIDER	Requestor's Name:	Fax:		Phone: E	xt.	
Medicaid/Medicare #:  Phone Number:  REQUESTING PROVIDER  WellCare ID:  Address:  City, State, ZIP  Phone:  Fax:  NPI/Tax ID:  SERVICING FACILITY  WellCare ID:  Address  Phone Number  Fax Number  Address  City, State, ZIP  Phone Number  Fax Number  Address  City, State, ZIP  SERVICING PROVIDER  WellCare ID:  NPI/Tax ID:  Facility Name:  Address  City, State, ZIP  SERVICING PROVIDER  WellCare ID:  NPI/Tax ID:  Facility Name:  Address  City, State, ZIP  Admission Info  Preplanned Admission	MEMBER					
REQUESTING PROVIDER  WellCare ID:	WellCare ID:	Last Name	:	First Name, MI:		
MellCare ID:  Address: City, State, ZIP  Phone: Fax: NPI/Tax ID:  SERVICING FACILITY  WellCare ID: Phone Number Address City, State, ZIP  Phone Number  SERVICING PROVIDER  WellCare ID: NPI/Tax ID: Facility Name: Address City, State, ZIP  SERVICING PROVIDER  WellCare ID: NPI/Tax ID: Facility Name: Phone Number Fax Number  Address City, State, ZIP  ADMISSION INFO Preplanned Admission Emergency Room Visit Observation Inpatient Admit LTACH SNF  Place of Service: 21 Inpatient Hospital 22 Outpatient Hospital 23 ER Hospital 31 Skilled Nursing Facility  Admission Date or Planned Admission Date: /_ / Requested length of stay: days  Primary ICD-10 Code: Description:  Primary CPT-4 Code: Description:  Please include additional procedures codes, as applicable, in the Clinical Summary below.	Medicaid/Medicare #:	Phone Number:		Date of Birth:		
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	Primary CPT-4 Code : Description:					
Pertinent Clinical Summary: (Attach supporting clinical records, if necessary).	Please include additional procedures codes, as applicable, in the Clinical Summary below.					
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