Outpatient Authorization Request

WellCare Health Plans

FAX TO : MEDICARE

Georgia : (877) 892-8213	**Arkansas:** (877)277-1820	**Connecticut :** (877) 892-8215	**Louisiana :** (866) 455-6488
Mississippi: (877)277-1820	**Illinois:** (877) 899-2044	**Kentucky:** (888) 361-5684	**NewYork:**(888)892-8214
Florida : (877) 892-8216	**South Carolina**: (877)277-1820	**New Jersey :** (877) 892-8221	**Texas:**(877)894-2034
			Tennessee: (877)277-1820

FAX TO : MEDICAID

Florida : (800) 935-5752	**Georgia :** (866) 455-6487	**Illinois :** (866) 867-9953	**Kentucky :** (877) 431-0950
Nebraska: (855)-292-0240	**New Jersey:** (888)342-6548	**New York :** (800) 246-7983	**S Carolina :** (888) 344-0376

PRIORITY LEVEL

☐Standard ☐ Post-service

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

CHECK ONE OF THE FOLLOWING:

☐ Ambulatory Surgery	☐ Dialysis	☐ Lab Services
☐ Office visit and/or Procedures	☐ Outpatient Hospital Service	☐ Radiation Therapy

Required Information: In order to ensure our members receive quality care, appropriate claims payment, and notification of servicing providers, please complete this form in its entirety. Please type or print in black ink and submit this request to the fax number above**.**

MEMBER INFORMATION

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

REQUESTING PROVIDER INFORMATION

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

TREATING PROVIDER INFORMATION

☐ **Out of Network** If yes, please provide reason:

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:**	

FACILITY INFORMATION

Type : ☐ Office ☐ OP Hospital ☐ Free Standing Facility Medical Record Number :

WellCare ID Number:	**NPI Number:**	
Facility Name:	**Phone Number:**	**Fax Number:**
Street Address:	**City, State:**	**Zip Code:**

SERVICE REQUESTED

Planned Date of Service : / /

Primary ICD-10 Code : Description :

CPT-4 Code(s)	Description(s)	Visits / Frequency

Please include additional procedures code and pertinent Clinical Summary below: (Attach supporting clinical records, if necessary).

*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.*