Transplant Authorization Request

WellCare | HERITAGE HEALTH

FAX TO: (813)283-5320 Save time! Submit and review your requests online @ https://provider.wellcare.com			
Requestor's Name:	**Fax:**	**Phone:**	**Ext.**
MEMBER			
WellCare ID:	**Last Name:**	**First Name, MI:**	
Medicaid/Medicare #:	**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:	**Phone Number:**	**Fax Number:**	
Address:	**City, State, Zip:**		
TREATING PROVIDER			
WellCare ID:	**NPI/Tax ID:**		
Treating Provider Name:	**Phone Number:**	**Fax Number:**	
Address:	**City, State, Zip:**		
TRANSPLANT INFO			
Global Surgery: ☐Transplant Consultation ☐Transplant Evaluation ☐Transplant Listing ☐Actual Transplant			
Transplant Type: ☐Bone Marrow ☐Solid Organ ☐Islet Cell ☐Stem Cell: Allogeneic / Autologous (Circle One)			
Solid Organ Type:			
Place of Service: ☐11 Office ☐19 Off-Campus OPH ☐21 Inpatient Hospital ☐22 On Campus-OPH ☐24 Ambulatory Surgery Center			
Planned Service/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.			
Pertinent Clinical Summary: (Attach supporting clinical records, if necessary).			