WellCare®
Beyond Healthcare. A Better You.

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Outpatient Authorization Request Form

***Indicates a required field**

Requirements: *Clinical information and supportive documentation should consist of current physician order, notes and recent diagnostics.* ***Notification is required for any date of service change.*** ***Expedited Requests:*** If the standard time for making a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call **1-866-231-1821**.

Fax completed form to: **1-866-455-6487**

Requestor Name: _____ **Fax*:** _____ **Phone*:** _____

MEMBER INFO (Please Print)		
WellCare ID*:	**Medicaid/Medicare ID:**	
Last Name*:	**First Name, MI*:**	**Date of Birth*:** / /

REQUESTING PROVIDER (Please Print)		
WellCare ID:	**NPI/Tax ID*:**	
Provider Name*:	**Address:**	
City, State, ZIP:	**Fax*:**	**Phone:**

SERVICING PROVIDER OR FACILITY (Please Print)		
WellCare ID:	**NPI/Tax ID*:**	
Provider/Facility Name*:	**Address:**	
City, State, ZIP:	**Fax*:**	**Phone:**

DIAGNOSIS CODES*			
ICD-10:	**ICD-10:**	**ICD:10**	**ICD:10**

REQUESTED SERVICES

☐Dialysis ☐Lab ☐Office visit/Procedure ☐Radiation Therapy ☐MRI ☐Sleep Study ☐X-rays ☐CT Scan

Place of Service (check one): ☐ **Office (11)** ☐ **Outpatient Hospital (22)** ☐ **Dialysis Center (65)** ☐ **Lab (81)**

Anticipated Service Date*: ___/___ /_____

PROCEDURE CODE(S)*	Description	PROCEDURE CODE(S)*	Description
CPT Code:		**CPT** Code:	
CPT Code:		**CPT** Code:	
CPT Code:		**CPT** Code:	

Some services may be delegated to Evicore, please check the QRG