WellCare
Beyond Healthcare. A Better You.

Want faster service? Use our Provider Portal @ provider.wellcare.com

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 **1-877-389-9457**

Fax completed form to: 1-877-431-0950

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

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

REQUESTING PROVIDER		
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:**

TREATING PROVIDER (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** ☐ **Office Visit/Procedure** ☐ **Radiation Therapy** ☐ **MRI** ☐ **Sleep Study** ☐ **X-Rays** ☐ **CT Scan**
☐**Other (please specify):** _____

Place of Service (check one): ☐ **Telehealth (02)** ☐ **Office (11)** ☐ **Outpatient Hospital (22)** ☐ **Dialysis Center (65)** ☐ **Lab (81)**
☐ **Other (please specify):** _____

Anticipated Service Date*: _____/ _____/ _____

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