WellCare

OUTPATIENT AUTHORIZATION REQUEST

Fax to: 877-277-1820

* Check one of the following:

☐ **Consultation** ☐ **Follow-Up Visit** ☐ **Diagnostic Testing** ☐ **Office Procedure**
☐ **Ambulatory Surgery** ☐ **Dialysis** ☐ **Radiation Therapy** ☐ **Out of Network Provider**
☐ **OB Services** ☐ **Transition of Care**

***Required Information –** In order to ensure our members receive quality care, appropriate claims payment and notification of servicing providers, all required fields on this form must be completed. Please type or print in black ink and submit this request to the fax number above. For an urgent* request, please call **(800)-951-7719** (do not fill-out this form).

Member

* Today's Date: _____/_____/_____
* Member Plan ID: _____ * DOB: _____/_____/_____
* Member Last Name: _____ * Member First Name: _____
Member Phone Number: _(_____)_____

Requesting Provider

* Provider ID: _____ * Type: __ PCP __ Specialist
* Provider Last Name: _____ * Provider First Name: _____
* Address: _____
* Phone Number: _(_____)_____ * Fax No.: _(_____)_____
* Specialty: _____ * RP Contact: _____

Treating Provider

☐ Check this box to skip this section and have the Plan assign the Treating Provider
* Provider ID: _____ * Specialty: _____
* Provider Last Name: _____ * Provider First Name: _____
* Phone Number: _(_____)_____ * Fax No.: _(_____)_____

Facility

* Type: ☐ Office ☐ OP Hospital ☐ Free Standing Facility Medical Record#: _____
☐ Check this box to skip this section and have the Plan assign the Facility
* Facility ID: _____ * Facility Name: _____
* Phone Number: _(_____)_____ * Fax No.: _(_____)_____

Service Requested

* Planned Date of Service: _____/_____/_____ EDD: _____
* Primary ICD-9 Code: _____ * Description: _____

* CPT-4 /HCPC Code	* Description of Procedure, Service	* Visits/Frequency

Please include additional procedure codes as may be applicable in the Clinical Summary below.

* Pertinent Clinical Summary: (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.*