Outpatient Notification / Authorization Request Form

WellCare

Fax To:

Connecticut	877-892-8215	**Florida**	877-892-8216	**Georgia**	877-892-8213
Illinois	877-899-2044	**Indiana**	888-275-8211	**Louisiana**	866-455-6488
Missouri	877-899-2033	**New Jersey**	877-892-8221	**New York**	877-892-8214
Ohio	877-851-2048	**Texas**	877-894-2034		

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**

☐ (POS) POINT OF SERVICE BENEFIT OPTION ELECTED BY MEMBER. Higher share of cost for member will apply

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

MEMBER

Member Plan ID: Today's Date:

Member Last Name: Member First Name:

Member Phone Number: Date of Birth:

REQUESTING PROVIDER

Provider ID: Type: ☐ PCP ☐ Specialist

Provider Last Name: Provider First Name:

Phone Number: Fax Number:

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:

Address: _____ City:_____ State:____ ZIP: _____

Phone Number: Fax Number:

FACILITY

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

☐ Check this box to skip this section and have the Plan assign the Facility

Facility ID: Facility Name:

Address: _____ City:_____ State:____ ZIP: _____

Phone Number: Fax Number:

SERVICE REQUESTED

Planned Date of Service: ___ / ____ / _____ EDD:

Primary ICD-9 Code: Description:

CPT- 4 / HCPC Code	Description of Procedure or Services	Visits / Frequency

Please include additional procedure codes, as 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.*