



Beyond Healthcare. A Better You.

Want faster service? Use our Provider Portal @ Provider.WellCare.com

Surgery Prior Authorization 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:

FACILITY (Please Print)

WellCare ID: NPI/Tax ID: Facility Name*: Address: City, State, ZIP: Fax*: Phone:

PHYSICIAN (SURGEON)

WellCare ID: NPI/Tax ID: Provider Name*: Address: City, State, ZIP: Fax*: Phone:

DIAGNOSIS CODES*

ICD-10: ICD-10: ICD:10 ICD:10

Place of Service (check one): Office (11) Inpatient Hospital (21) Outpatient Hospital (22) Ambulatory Surgery Center (24)

Planned/Anticipated Surgery Date*: ___/___/___

Table with 4 columns: PROCEDURE CODE(S)*, Description, PROCEDURE CODE(S)*, Description. Contains 3 rows for CPT codes.

Include all supporting clinicals and additional codes if needed