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Home Health Authorization Request

*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 1-855-538-0454

Fax completed form to 1-855-754-8483

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:	
HOME HEALTH AGENCY (Please Print)				
WellCare ID:		<input type="checkbox"/> Plan to Assign	NPI/Tax ID*:	
Provider Name*:		Address:		
City, State, ZIP:		Fax*:	Phone:	
REQUESTED SERVICES* (Please Print)				
PT, OT and other Home Health Services may be delegated to Evicore or Coastal Care, please check the QRG				
Are services needed for discharge planning? (circle one) Y / N			Discharge Date: ___/___/___	
ICD-10 Code*:	ICD-10 Code:	ICD-10 Code:	ICD-10 Code:	
Service Requested*	Procedure Code*	Start Date*	End Date	Frequency
Skilled Nursing				___ days a week for ___ weeks = ___ visits
Home Health Aid				___ days a week for ___ weeks = ___ visits
MSW (Social Worker)				___ days a week for ___ weeks = ___ visits
Physical Therapy				___ days a week for ___ weeks = ___ visits
Occupational Therapy				___ days a week for ___ weeks = ___ visits
Speech Therapy				___ days a week for ___ weeks = ___ visits
Episode of Care (Medicare Only) – No codes required				___ days a week for ___ weeks = ___ visits

Some services may be delegated to EviCore or Coastal Care. Please check the QRG