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

Skilled Therapy Authorization Request

***Indicates a required field**

Requirements: *Clinical information and supporting 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 to make 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.

Please fax completed form to the appropriate number at the end of this document.

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:**

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:**

REQUESTED SERVICES (please choose only one)			
☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Massage Therapy ☐ Equine Therapy ☐ Aquatic Therapy ☐ Other (please specify):_____ **PT and OT service may be delegated to eviCore. Please check the QRG** ***Massage therapy for Florida is not to be redirected to eviCore***			
Place of Service (check one): ☐ Office (11) ☐ Hospital (22) ☐ Home (12)			
Date of last therapy evaluation or reevaluation:	PT: / /	OT: / /	ST: / /
Attach a copy of the therapy evaluation / reevaluation or progress summary (acute) for each therapy discipline requested.			

DIAGNOSIS CODE(S)*			
ICD-10:	ICD-10:	ICD-10:	ICD-10:

Procedure Code	Description	Frequency
CPT Code:		_____ days a week for _____ weeks = _____ visits
CPT Code:		_____ days a week for _____ weeks = _____ visits
CPT Code:		_____ days a week for _____ weeks = _____ visits
CPT Code:		_____ days a week for _____ weeks = _____ visits

Fax completed form to:

Medicare Fax Lines		
Arizona Value (HMO) 1-855-754-8483	Arizona Patriot (PPO) 1-866-246-9832	Connecticut 1-866-455-6529
Florida Medicare Only 1-877-892-8216	Georgia Medicare Only 1-877-892-8213	Florida/Georgia Dual 1-877-277-1820
Illinois 1-877-899-2044	Kentucky 1-888-361-5684	New Jersey 1-877-892-8221
New York 1-877-892-8214	Texas 1-877-894-2034	All others 1-888-361-5684