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INPATIENT 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 **1-888-588-9842**.

Fax completed form to: 1-888-343-6242

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:
ATTENDING PHYSICIAN (Please Print)		
WellCare ID:	NPI/Tax ID*:	
Provider Name*:	Address:	
City, State, ZIP:	Fax:	Phone:

DIAGNOSIS CODES			
ICD-10*:	ICD-10:	ICD:10	ICD:10

☐Observation ☐Inpatient Admission ☐LTACH ☐SNF/Sub-Acute Rehab ☐Inpatient Rehab ☐Waitlist ☐ICF

Date of Admission*:	Is this a Level of Care Change (OBS to INP)? Y / N Observation Admit Date:
PROCEDURE CODE(S)	**DESCRIPTION**
CPT/HCPC Code:	
CPT/HCPC Code:	

Some authorizations may be delegated to CareCentrix, please check the QRG

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