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Outpatient Authorization Request 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: 1-888-344-0376

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:
DIAGNOSIS CODES*			
ICD-10:	ICD-10:	ICD-10:	ICD-10:
REQUESTED SERVICES			
<input type="checkbox"/> Dialysis <input type="checkbox"/> Lab <input type="checkbox"/> Office visit/Procedure <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> MRI <input type="checkbox"/> Sleep Study <input type="checkbox"/> X-rays <input type="checkbox"/> CT Scan			
Place of Service (check one): <input type="checkbox"/> Office (11) <input type="checkbox"/> Outpatient Hospital (22) <input type="checkbox"/> Dialysis Center (65) <input type="checkbox"/> Lab (81)			
Anticipated Service Date*: ___/___/___			
PROCEDURE CODE(S)*	Description	PROCEDURE CODE(S)*	Description
CPT Code:		CPT Code:	
CPT Code:		CPT Code:	
CPT Code:		CPT Code:	

Some services may be delegated to Evicore, please check the QRG