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Skilled Therapy 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 1-888-588-9842.

Fax completed form to 1-877-709-1698

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 (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	
Place of Service (check one): <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Other, please specify: _____				
Date of last Therapy Evaluation or Re-Evaluation:	PT:	OT:	ST:	
Attach a copy of the therapy evaluation/re-evaluation or progress summary (acute) for each therapy discipline requested below. **Do not use the Evaluation Date as the start date for services.**				
Service Requested	Procedure Code*	Start Date*	End Date	Frequency
Physical Therapy				___ days a week for ___ weeks = ___ visits
Occupational Therapy				___ days a week for ___ weeks = ___ visits
Speech Therapy				___ days a week for ___ weeks = ___ units
Other:				___ days a week for ___ weeks = ___ visits

PT and OT services may be delegated to EviCore, please check the QRG