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Inpatient Authorization Request Form

***Indicates a required field**

Requirements: *Clinical information and supporting documentation should consist of current physician orders, 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: 1-855-776-9464.

Requestor Name:_____ **Fax*#:** _____ **Phone*#:** _____

MEMBER INFO (Please Print)		
Wellcare ID*:	**Medicaid/Medicare ID:**	
Last Name*:	**First Name, MI*:**	**Date of Birth*: / /**

REQUESTING PROVIDER		
Wellcare ID:	**NPI/Tax ID*:**	
Provider Name*:	**Address:**	
City, State, ZIP:	**Fax*:**	**Phone:**

FACILITY (Please Print)		
Wellcare ID:	**NPI/Tax ID*:**	
Provider/Facility Name*:	**Address:**	
City, State, ZIP:	**Fax*:**	**Phone:**

ATTENDING PROVIDER (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

☐ Observation ☐ Inpatient Admission ☐ LTACH ☐ SNF/Sub-Acute Rehab ☐ Inpatient Rehab ☐ Waitlist ☐ ICF ☐ **Other (please specify):**_____

Place of Service (check one): ☐ ALF (13) ☐ Observation Hospital (22) ☐ Inpatient (21) ☐ SNF (31) ☐ Nursing Facility (32)

Date of Admission*: _____ / _____ / _____	**Is this a Level of Care Change (OBS to INP)? ☐Yes ☐ No** **Observation Admit Date: / /**

PROCEDURE CODE(S)*	Description	PROCEDURE CODE(S)	Description
CPT Code:		**CPT Code:**	
CPT Code:		**CPT Code:**	

CPT Code:		**CPT Code:**	