WellCare
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Home Health 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 **1-855-538-0454**

For Medicare ONLY Members, fax form to: (877) 892-8213
For Dual Eligible Members (members with Medicare and Medicaid policies), fax form to: (855) 292-0233
Discharge Planning fax to: **(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 (Please Print)		
WellCare ID:	NPI/Tax ID*:	
Provider Name*:	Address:	
City, State, ZIP:	Fax*:	Phone:

HOME HEALTH AGENCY (Please Print)			
WellCare ID:	☐ Plan to Assign	NPI/Tax ID*:	
Provider Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:

REQUESTED SERVICES* (Please Print)
PT, OT and other Home Health Services may be delegated to Evicore or Coastal Care, please check the QRG

Are services needed for discharge planning? (circle one) Y / N		Discharge Date:___/___/_____	
ICD-10 Code*:	ICD-10 Code:	ICD-10 Code:	ICD-10 Code:

Service Requested*	Procedure Code*	Start Date*	End Date	Frequency
Skilled Nursing				___ days a week for___weeks =___visits
Home Health Aid				___ days a week for___weeks =___visits
MSW (Social Worker)				___ days a week for___weeks =___visits
Physical Therapy				___ days a week for___weeks =___visits
Occupational Therapy				___ days a week for___weeks =___visits
Speech Therapy				___ days a week for___weeks =___visits
Episode of Care (Medicare Only) – No codes required				___ days a week for___weeks =___visits

Some services may be delegated to EviCore or Coastal Care. Please check the QRG