WellCare
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# Surgery Prior 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 **1-855-538-0454**

**Fax completed form to**: **1-877-899-2044**

**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:** |

| **PHYSICIAN (SURGEON)** | | |
|---|---|---|
| **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):** ☐ **Office (11)** ☐ **Inpatient Hospital (21)** ☐ **Outpatient Hospital (22)** ☐ **Ambulatory Surgery Center (24)**

**Planned/Anticipated Surgery Date*:** ___/___ /_____

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

**Include all supporting clinicals and additional codes if needed**