WellCare
Beyond Healthcare. A Better You.

For Faster, Self-Service:
Provider.WellCare.com

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Outpatient: 1-866-319-2691
Inpatient: 1-800-678-3170
BH Outpatient: 1-866-587-1383
BH Inpatient: 1-800-551-0325

NORTH CAROLING MEDICAID PRIOR AUTHORIZATION REQUEST

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The beneficiary must be NC Medicaid eligible on the date of service or date the equipment or prosthesis is received by the beneficiary. **See reverse side for instructions.**

I. GENERAL INFORMATION

1.	2. Name: (Last, First, M.I.)	3. Date of Birth
4. Address (Street, City, State, Zip Code)		5. NC Medicaid ID Number

6. Prognosis	7. Diagnosis Code	8. Diagnosis Description

9. Name and address of facility where services are to be rendered, if other than home or office.

II. (EPSDT) SERVICE REQUEST (MAY REQUIRE PLAN OF CARE)

10. Date of screening	11. Screening ☐ Full ☐ Interperiodic ☐ Partial	12. Type of Partial Screening
13. Screening Provider Name	14. Provider Identifier	15. Telephone Number

III. SERVICE INFORMATION

16. REF NO	17. Procedure Code	18. Modifiers				19. From	20. Through	21. Description of Service/Item	22. QTY or Units	23. Amount to be Charged	FOR STATE USE ONLY: APPR.	Denied	Amount Allowed if Priced by Report
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													

24. Detailed explanation of Medical Necessity for Services/Equipment/Procedure/Prosthesis (Attach additional pages if necessary)

IV. PROVIDER

25. Provider Name

26. Address

27. Fax Number

28. NPI	Taxonomy
29. Signature	Date

V. PRESCRIBING/PERFORMING PRACTITIONER

30. Name	31. Telephone
32. Address	
33. Date Disability Began	34. Period of Medical Need in Months
35. NPI	Taxonomy

I certify that the information given in Sections I and III of this form is true, accurate, and complete.

36. Signature of Prescribing Physician/Practitioner	Date

VI. FOR STATE OFFICE USE ONLY

Denial Reason(s): Refer to field 16 above by reference numbers (REF NO.)

IF APPROVED: Services Authorized to Begin	Date	Reviewed by Signature ▸

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INSTRUCTIONS FOR COMPLETION

GENERAL INFORMATION - To be completed by the provider requesting the prior authorization

1. Leave blank
2. Beneficiary's Name - Enter the beneficiary's name as it appears on the NC Medicaid Identification Card. Enter the beneficiary's current address.
3. Date of Birth - Enter the beneficiary's date of birth.
4. Address - Enter the beneficiary's address, city, state, and zip.
5. NC Medicaid number - Enter the beneficiary's NC Medicaid Identification number as shown on the NC Medicaid Identification card or county letter of eligibility.
6. Prognosis - Enter the beneficiary's prognosis.
7. Diagnosis Code - Enter the diagnosis code(s).
8. Diagnosis Description - Enter the diagnosis description. if there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered, if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of Screen - Enter the date the screen was done.
11. Screening - Check whether the screening performed was Full, Interperiodic, or Partial.
12. Type of Partial Screen - Enter the type of partial screen that was performed. (e.g., vision, hearing, etc.)
13. Screening Provider Name - Enter the provider's name who performed the screening.
14. Provider Identifier - Enter the provider's NPI number who performed the screening.
15. Telephone Number - Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. NO. - (Reference number) a unique designator (1-12) identifying each separate line on the request.
17. Procedure Code - Enter the procedure code(s) for the services being requested.
18. Modifier - Enter the appropriate modifier(s) for the services being requested.
19. From - Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through - Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item - Enter a specific description of the service/item being requested.
22. Quantity or Units - Enter the quantity or units of service/item being requested.
23. Amount to be Charged - Enter the amount to be charged for the service.
24. Detailed explanation of medical necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary. **Do not use another Prior Authorization Form.**

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name - Enter the requested provider's information. if a clinic or group practice, also complete section v.
26. Address - Enter the complete mailing address in this field.
27. Fax Number – Enter the provider's fax number.
28. NPI - Enter the provider's NPI and taxonomy code (if applicable).
29. Signature/Date - The provider of services should sign the request and indicate the date the form was completed. (Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as durable medical equipment, physical therapy, or for services which will be prescribed by a physician/practitioner that require prior authorization, or when the provider in section iv is a clinic or group practice. Check your provider manual for additional instructions.

30. Name - Enter the name of the prescribing/performing practitioner.
31. Telephone Number - Enter the prescribing/performing practitioner telephone number including area code.
32. Address - Enter the address, city, state, and zip code.
33. Date Disability Began - Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
34. Period of Medical Need in Months - Enter the estimated number of months the beneficiary will need the equipment/services.
35. NPI - Enter the provider's NPI and taxonomy code (if applicable).
36. Signature of Prescribing/Performing Practitioner - The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also, in this box the consultant will indicate allowed amount, if procedure requires manual pricing. At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 12). The consultant will sign or initial the form.