WellCare®
Beyond Healthcare. A Better You.

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INPATIENT 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 **1-866-231-1821**.

Fax completed form to: 1-877-431-8860

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:**

ATTENDING PHYSICIAN (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**

☐Observation ☐Inpatient Admission ☐LTACH ☐SNF/Sub-Acute Rehab ☐Inpatient Rehab ☐Waitlist ☐ICF

Date of Admission*:	**Is this a Level of Care Change (OBS to INP)? Y / N Observation Admit Date:**

PROCEDURE CODE(S)	DESCRIPTION
CPT/HCPC Code:	
CPT/HCPC Code:	

Some authorizations may be delegated to CareCentrix, please check the QRG