WELLSPACE
NEXUS LLC

AUTHORIZATION REQUEST FORM

1. REFFERAL	
☐ Urgent (non life-threatening) ☐ Routine ☐ Appeal ☐ Retro-DOS:_____	☐ Request to update a decisioned auth (#) _____ ☐ Redirect ☐ Add Code ☐ Extension ☐ Quantity change

2. GENERAL INFORMATION				
PATIENT NAME:	DATE OF BIRTH:	NAME OF GUARANTOR:		
ADDRESS:	CITY:	STATE:	ZIP:	PHONE #
MEMBER ID #	SUBSCRIBER NAME:			

PCP:	REQUESTING PROVIDER:	CONTACT PERSON:	PHONE #	FAX #
REFFERAL TO: If unknown put specialty	SPECIALTY:	CONTACT PERSON:	PHONE #	FAX #
STREET ADDRESS (If out of network):			CITY:	ZIP:
FACILITY NAME:				

3.SERVICES

☐ New Consult ☐ Follow-up Visit ☐ Outpatient ☐ Inpatient ☐ DME ☐ Home Health ☐ Other

Diagnosis ICD 10: _____

CPT CODE:	QTY:	CPT CODE:	QTY:

INSTRUCTIONS:

1. Fax completed referral forms to: (916) 914-2039
2. Authorization Department Telephone: (916) 737-5577
3. Authorization are valid for 6 months. Pharmacy authorizations are valid for 3 months.
4. To prevent delays, please attach any consultation, imaging reports and/or pertinent documentation to support Medical Necessity for requested service.