WellCare®
Beyond Healthcare. A Better You.

For Faster, Self-Service: provider.wellcare.com
PRIOR AUTHORIZATION REQUEST

Clinical information and supportive documentation should consist of current physician order, notes and recent diagnostics. ***Notification is required for any date of service change.***

Date: _____ Requesting Provider _____
NPI # _____ TIN # _____
Contact Name _____Telephone # _____ Fax #_____

Type of Request

☐ Urgent (*Urgent is defined as 'significant impact to health of member')*

☐ Non-Urgent ☐Pre-Service ☐ Post-Service (Retro) ☐ Concurrent ☐ Emergent

Member Information

Member Name _____ Medicaid ID # _____ WellCare ID# _____
Address (Street, City, State, Zip Code) _____ Date of Birth _____
Is the member pregnant? ☐ Yes ☐ No
Member's PCP _____ Phone _____ NPI _____

Treating/Servicing Provider Information ☐ Same a Requesting

Provider Name _____ WellCare ID _____NPI_____ Tax ID# _____
Address_____ City _____ State _____ ZIP _____
Phone _____ Fax# _____
Are any supporting documents included? ☐ Yes ☐ No Number of documents _____

Facility/Ancillary Information

Facility/Ancillary Name _____ WellCare ID _____NPI_____ Tax ID# _____
Address_____
City _____ State _____ ZIP _____ Phone _____ Fax# _____
Are any supporting documents included? ☐ Yes ☐ No Number of documents _____

Type of Service

BEHAVIORAL HEALTH SERVICES

☐ Behavioral Health – Intensive Outpatient ☐ Behavioral Health – CSU ☐ Behavioral Health – Inpatient ☐ Behavioral Health – Sub Acute
☐ Behavioral Health – Detox ☐ Behavioral Health – Routine Outpatient ☐ Behavioral Health – Case Management ☐ Behavioral Health – Residential
☐ Behavioral Health – Rehabilitation ☐Behavioral Health – ECT ☐ **Other _____**

MEDICAL SERVICES

☐ DME Purchase ☐ DME Rental ☐ Home Health ☐ Inpatient Admission ☐ Inpatient Rehab ☐ LTACH ☐ Skilled Therapy (PT/OT/ST)
☐ SNF ☐ Surgery – Outpatient ☐ Surgery – Pre-Planned Inpatient ☐ **Other _____**

TRANSPORTATION – ☐ Air ☐ Land Mileage: _____ Trips: _____ O2 Needed: ☐Yes ☐No
Pick Up Address (Street, City, State, Zip Code) _____
Drop Off Address (Street, City, State, Zip Code) _____

Place of Service

☐ 11 – Office ☐ 12 – Home ☐ 21 – Inpatient ☐ 22 – Outpatient ☐ 24 – Ambulatory Surgery Center ☐ 41 – Land Ambulance
☐ 41 - Air Ambulance ☐ 51 – Inpatient Psychiatric Hospital ☐ 53 – Community Mental Health Center ☐ Other _____

Clinical Information: Request MUST include medical documentation to be reviewed for medical necessity

ICD-10	ICD-10	ICD-10	ICD-10

Dates of Service		Procedure/ Service Codes	Description	Requested Units/Visits/Days (please specify)
Start	Projected End Date			

North Carolina Medicaid
Prior Authorization Phone Numbers

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 **1-866-799-5318**

DEPARTMENT	PHONE	FAX
All Medical	**1-866-799-5318**	Inpatient – **1-800-678-3170** Outpatient – **1-866-319-2691**
Behavior Health	**1-866-799-5318**	Outpatient – **1-866-587-1383** Inpatient – **1-800-551-0325**