WellCare
Beyond Healthcare. A Better You.

Want faster service? Use our Provider Portal @ Provider.WellCare.com

Value-Added Benefit Referral 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 **1-866-799-5318**.

Fax completed form to: **1-866-319-2691**

Requestor Name: _____ **Fax*:** _____ **Phone*:** _____

MEMBER INFO (Please Print)		
WellCare ID*:	**Medicaid ID:**	
Last Name*:	**First Name, MI*:**	**Date of Birth*: / /**

REQUESTING PROVIDER (Please Print)		
WellCare ID:	**NPI/Tax ID*:**	
Provider Name*:	**Address:**	
City, State, ZIP:	**F ax*:**	**Phone:**

SERVICING PROVIDER OR FACILITY (Please Print)		
WellCare ID:	**NPI/Tax ID*:**	
Provider/Facility Name*:	**Address:**	
City, State, ZIP:	**Fax*:**	**Phone:**

DIAGNOSIS CODES*			
ICD-10:	**ICD-10:**	**ICD:10**	**ICD:10**

REQUESTED SERVICES

Place of Service (check one): ☐ **Office (11)** ☐ **Home (12)** ☐ **Telehealth (03)** ☐ **Stable – Equine (99)**
☐ **Other (99)** _____

Service Requested*	**Procedure Code***	**Start Date***	**End Date**	**Frequency**
Art Therapy	**G0176**			**____ days a week for ___ weeks = ____visits**
Equine Therapy	**S8940**			**____ days a week for ___ weeks = ____visits**
Parent Support & Training	**T0127**			**____ days a week for ___ weeks = ____visits**