



REQUEST FOR REFERRAL/CERTIFICATION

Fax to: _____ (based on the member's county of residence – see attached)

MEMBER INFORMATION, DIAGNOSIS (ICD-9 CODE) & TREATMENT (HCPCS/CPT CODE)

* Request Type: Routine _____ Stat _____ Expedited _____
Request Date: _____ Request for Hospital Admission or Observation? Yes _____ No _____
Member Name: _____ Member Date of Birth: _____
Member ID #: _____ Member Telephone #: _____
Diagnosis: _____ ICD-9 Code: _____
Requested days/visits: _____ Expiration Date: _____
Start/Service Date: _____ HCPCS/CPT Code: _____
Service Requested: _____

REQUESTED BY

Physician: _____ Address: _____
WellCare Provider #: _____ City: _____ State: _____ Zip: _____
TIN# _____ Telephone #: _____ Fax #: _____

REFERRED TO

Physician/Provider: _____ Address: _____
WellCare Provider #: _____ City: _____ State: _____ Zip: _____
Facility Name: _____ Telephone #: _____ Fax #: _____
Facility Address: _____
City: _____ State: _____ Zip: _____

RESPIRATORY EQUIPMENT

Oxygen: _____ Concentrator: _____ Liter Flow: _____ (Requires O2 Sat% +/-Date)
C Pap/B Pap: _____ Settings: _____ (Studies req.) Nebulizer: _____ Masks/Kits: _____
Trach Supplies (specify) _____

DME

Member Weight: _____ Height: _____ (Required to ensure appropriate size) W/C: _____
Hospital Bed: _____ Walker: _____ Quad Cane: _____ BSC: _____ Special equipment needs: _____

Clinical Information: _____

Delivery Address: _____ City: _____ State: _____ Zip: _____
Phone # 1: _____ Phone # 2: _____

* See Provider Manual for definition of routine, stat and expedited.

Authorizations are not a guarantee of payment. Payment of claims is subject to a member's eligibility, covered benefits, limitations and exclusions on the date of service and to any other contractual provision of the plan.

Physician's Signature _____