WellCare
Beyond Healthcare. A Better You.

Want faster service? Use our Provider Portal @ provider.wellcare.com

Skilled Therapy Authorization Request

***Indicates a required field**

Requirements: *Clinical information and supporting 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 to make a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call 1-855-538-0454.
Fax completed form to appropriate number at bottom of form.

Requestor Name:______________________ **Fax*#:** ______________________________ **Phone*#:** _____________________________

MEMBER INFO (Please Print)		
WellCare ID*:	Medicaid/Medicare ID:	
Last Name*:	First Name, MI*:	Date of Birth*: / /
REQUESTING PROVIDER		
WellCare ID:	NPI/Tax ID*:	
Provider Name*:	Address:	
City, State, ZIP:	Fax*:	Phone:
SERVICING PROVIDER OR FACILITY (Please Print)		
WellCare ID:	NPI/Tax ID*:	
Provider/Facility Name*:	Address:	
City, State, ZIP:	Fax*:	Phone:
TREATING PROVIDER (Please Print)		
WellCare ID:	NPI/Tax ID*:	
Provider/Facility Name*:	Address:	
City, State, ZIP:	Fax*:	Phone:

REQUESTED SERVICES (please choose only one)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Massage Therapy ☐ Equine Therapy
☐ Aquatic Therapy ☐Other(please specify): ____

****PT and OT service may be delegated to eviCore. Please check the QRG****
*****Massage therapy for Florida is not to be redirected to eviCore*****

Place of Service (check one):	☐ Office (11) ☐ Hospital (22) ☐ Home (12) ☐ Other (please specify):		
Date of last Therapy Evaluation or Re-Evaluation:	PT: / /	OT: / /	ST: / /

Attach a copy of the therapy evaluation/re-evaluation or progress summary (acute) for each therapy discipline requested

DIAGNOSIS CODE(S)*			
ICD-10:	ICD-10:	ICD-10:	ICD-10:

Procedure Code	Description	Frequency
CPT Code:		__________ days a week for __________ weeks = __________ visits
CPT Code:		__________ days a week for __________ weeks = __________ visits
CPT Code:		__________ days a week for __________ weeks = __________ visits
CPT Code:		__________ days a week for __________ weeks = __________ visits

©WellCare 2021

Fax completed form to:

Medicare Fax Lines		
Arizona Value (HMO) 1-855-754-8483	Arizona Patriot (PPO) 1-866-246-9832	Connecticut 1-866-455-6529
Florida Medicare Only 1-877-892-8216	Georgia Medicare Only 1-877-892-8213	Florida/Georgia Dual 1-877-277-1820
Illinois 1-877-899-2044	Kentucky 1-888-361-5684	New Jersey 1-877-892-8221
New York 1-877-892-8214	Texas 1-877-894-2034	All others 1-888-361-5684

©WellCare 2021