



Inpatient Precertification

Request Priority

- ☐ Standard
- ☐ Expedited (choose appropriate rationale)
- ☐ Seriously jeopardize the life or health of the member or the member's ability to regain maximum function
- ☐ Subject the member to severe pain that cannot be adequately managed without the care of treatment requested

This form should ONLY be used by providers that do not have access to the Utilization Management Tool.

- ☐ Form contains Personal Identifiable Information related to a Substance Use Disorder (SUD) services request. Member consent has been obtained to release information to Wellmark for treatment, payment of claims, health care operations, and for Wellmark to re-disclose information with the current treating and future treating entities related to request.

Patient's Name (Last, First, Middle Initial)		Wellmark ID Number		Patient's Date of Birth / /	
Policyholder Name (Last, First, Middle Initial)		Patient's Gender ☐ Male ☐ Female		Relationship to Policyholder ☐ Self ☐ Spouse ☐ Dependent	
Address		Sender Telephone Number		Sender Fax Number	
City, State, ZIP Code		Diagnosis Code			
Admitting Provider (Last, First, Middle Initial)		Facility			
Admitting Provider NPI		Facility NPI			
Address		Address			
City, State, ZIP Code		City, State, ZIP Code			
Additional Information (Attach medical necessity documentation as necessary, including relevant CPT codes.)					
Inpatient Stay Information					
Is this the initial review? ☐ Yes ☐ No Utilization Review Telephone Number _____					
If yes, has the member already been admitted? ☐ Yes ☐ No					
Is this a concurrent/continued stay review? ☐ Yes ☐ No					
Admission Date ____/____/____ Discharge Date ____/____/____ Length of Stay Requested ____					
Requested Level of Care (Select One)					
☐ Acute Behavioral Health		☐ Acute Rehabilitation		☐ Acute Substance Use Disorder	
☐ Hospice		☐ Long Term Acute Care		☐ Medical Acute	
☐ NICU		☐ PMIC		☐ Residential Behavioral Health	
☐ Residential Substance Use Disorder		☐ Skilled Nursing Facility		☐ Surgical Acute	

I certify the accuracy and completeness of all information reported by me on this form.

Provider Signature _____ Date ____/____/____

Wellmark will only review CPT codes that are found on the Authorization Table.

Provider: Please complete this form and submit it to Wellmark to the fax number given below.

Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Blue Cross and Blue Shield of South Dakota
Utilization Management Department
Fax: 515-376-9105

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