



Prior Authorization Request Form

Please Expedite*

Justification for Expedited Request:

If no justification given, request will be processed as standard

Submit requests to:

Online: welcome.wellmark.com

Fax: 866-313-8595

Phone: 855-673-4225

*Please ONLY check this option if the provider believes that for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy (CMS definition)

1. Member Information & Background

Patient Name: _____	Previous auth # (if applicable): _____
Member/Patient ID Number: _____	Contact Name: _____
Patient DOB: _____ Pt. phone: _____	Contact Phone: _____ Fax: _____
Patient Address: _____	Requesting Provider: _____
_____	Requesting Provider NPI#: _____
ICD-10 Code(s): _____	Treating Provider: _____
CPT/HCPCS Code(s): _____	Treating Provider NPI#: _____
Date of Admission/Procedure: _____ TBD	<i>Inpatient requests, include these providers:</i>
Type: IP Hospital Office Surgery DME	Admitting Provider: _____
OP Diagnostics OP Surgery/ASC #	Admitting Provider NPI#: _____
Visits/Units/Days: _____	Servicing Facility: _____
Authorization Date Span: _____ - _____	Svc Facility NPI#: _____

For inpatient services only: If overnight admission is planned, please provide justification (e.g. procedure on CMS inpatient only list). **Note:** Must specify IP admission with appropriate code in CPT Code field above or services are assumed & reviewed as OP setting.

Comments:

This form must be filled out completely. Chart notes are required and need to be submitted with this request. Incomplete requests will be returned to the requester.

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