Wellmark Advantage Health Plan

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CLEAR FORM

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: _____

Member/Patient ID Number:_____

Patient DOB:_____Pt. phone: _____

Patient Address: _____

_____

ICD-10 Code(s):_____

CPT/HCPCS Code(s):_____

Date of Admission/Procedure:_____ ☐ TBD

Type: ☐ IP Hospital ☐ Office Surgery ☐ DME

☐ OP Diagnostics ☐ OP Surgery/ASC #

Visits/Units/Days:_____

Authorization Date Span:_____-_____

Previous auth # (if applicable):_____

Contact Name: _____

Contact Phone: _____ Fax: _____

Requesting Provider:_____

Requesting Provider NPI#:_____

Treating Provider:_____

Treating Provider NPI#: _____

Inpatient requests, include these providers:

Admitting Provider: _____

Admitting Provider NPI#:_____

Servicing Facility:_____

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.