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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.

Please fax completed form to the appropriate number at the end of this document.

Requestor Name\*: \_\_\_\_\_ Fax\*#: \_\_\_\_\_ Phone\*#: \_\_\_\_\_

MEMBER INFO (Please Print)
Wellcare ID\*: \_\_\_\_\_ Medicaid/Medicare ID: \_\_\_\_\_
Last Name\*: \_\_\_\_\_ First Name, MI\*: \_\_\_\_\_ Date of Birth\*: / /
REQUESTING PROVIDER (Please Print)
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)     Home (12)  
 Hospital (22)     Other (please specify): \_\_\_\_\_

Date of last therapy evaluation or reevaluation:	PT: / /	OT: / /	ST: / /
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Attach a copy of the therapy evaluation / reevaluation or progress summary (acute) for each therapy discipline requested.

**DIAGNOSIS CODE(S)\***

ICD-10:	ICD-10:	ICD-10:	ICD-10:
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Procedure Code	Description	Frequency
CPT Code:		_____ days a week for _____ weeks = _____ visits
CPT Code:		_____ days a week for _____ weeks = _____ visits
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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