WellCare
Beyond Healthcare. A Better You.

Want faster service? Use our Provider Portal @ Provider.WellCare.com

EPSDT Authorization Form

*Indicates a required field

Requirements: *Clinical information and supportive 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 for making a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call **1-866-334-7927**.

Fax completed form to: 1-800- 935-5752

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:

DIAGNOSIS CODES*			
ICD-10:	ICD-10:	ICD:10	ICD:10

REQUESTED SERVICES

Place of Service (check one): ☐ Office (11) ☐ Home (12) ☐ Telehealth (03) ☐ Stable - Equine (99) ☐ Other (99)

Service Requested*	Procedure Code*	Start Date*	End Date	Frequency
Art Therapy	G0176			____ days a week for _____ weeks = ______visits
Pet Therapy	G0176			____ days a week for _____ weeks = ______visits
Equine Therapy	S8940			____ days a week for _____ weeks = ______visits
Other Procedure Code				____ days a week for _____ weeks = ______visits

©WellCare 2020