

Transplant Authorization Request



FAX TO: (813)283-5320

Save time! Submit and review your requests online @ <https://provider.wellcare.com>

Requestor's Name:		Fax:	Phone:	Ext.:
MEMBER				
WellCare ID:	Last Name:		First Name, MI:	
Medicaid/Medicare #:	Phone Number:		Date of Birth:	
REQUESTING PROVIDER				
WellCare ID :	Provider/Facility Name:			
Address:	City, State, Zip:			
Phone:	Fax:	NPI/Tax ID:		
SERVICING FACILITY				
WellCare ID:	NPI/Tax ID:			
Facility Name:	Phone Number:		Fax Number:	
Address:	City, State, Zip:			
TREATING PROVIDER				
WellCare ID:	NPI/Tax ID:			
Treating Provider Name:	Phone Number:		Fax Number:	
Address:	City, State, Zip:			
TRANSPLANT INFO				
Global Surgery: <input type="checkbox"/> Transplant Consultation <input type="checkbox"/> Transplant Evaluation <input type="checkbox"/> Transplant Listing <input type="checkbox"/> Actual Transplant				
Transplant Type: <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Solid Organ <input type="checkbox"/> Islet Cell <input type="checkbox"/> Stem Cell: Allogeneic / Autologous (Circle One)				
Solid Organ Type:				
Place of Service: <input type="checkbox"/> 11 Office <input type="checkbox"/> 19 Off-Campus OPH <input type="checkbox"/> 21 Inpatient Hospital <input type="checkbox"/> 22 On Campus-OPH <input type="checkbox"/> 24 Ambulatory Surgery Center				
Planned Service/Admission Date: ___/___/___			Requested length of stay: ___ days	
Primary ICD-10 Code: _____ Description: _____				
Primary CPT-4 Code:				
Description:				
Please include additional procedures codes, as applicable, in the Clinical Summary below.				
Pertinent Clinical Summary: (Attach supporting clinical records, if necessary).				