Transplant Authorization Request

FAX TO: (866) 753-5659
Save time! Submit and review your requests online @ 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:**	
Facility Name:	**Phone Number:**	**Fax Number:**
Address:	**City, State, Zip:**	

TRANSPLANT INFO

☐Transplant Consultation ☐Transplant Evaluation ☐Transplant Listing ☐BMT/Stem Cell Surgery

Transplant Surgery:
☐Bone Marrow ☐Solid Organ ☐Islet Cell ☐Stem Cell (Circle one) Auto/Allo

Place of Service:
☐11 Office ☐19 Off-Campus OPH ☐21 Inpatient Hospital ☐22 On Campus-OPH
☐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).

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