



Provider Tip Sheet: Prior Authorization Requests

Improve Efficiency and Reduce Delays

This guide provides **general tips for submitting complete documentation** and includes additional details for select review areas where incomplete information is most common. Use it to help reduce delays, minimize back-and-forth, and support timely, accurate prior authorization decisions that improve patient care.

How to Use This Tip Sheet

- ✓ Start with the General Prior Auth Checklist.
- ✓ Then review the service-specific table for your request type (DME, Genetic Testing, Therapy, Home Health/CIS Rehab).
- ✓ Submit all required documentation with the initial request to avoid delays.

General Submission Tips

Tip	Why It Matters
Provide the Most Current Documents	Outdated notes can trigger Requests for Information (RFIs) and delays.
Respond Promptly to RFIs	Keeps the review moving and avoids expiration windows.
Organize the Packet	Clear labeling and ordered documents reduce rework.
Avoid Duplicates/Extra Pages	Prevents confusion and speeds review.
Verify identifiers (NPI/TIN, Member Name/DOB, Phone/Fax, Member Diagnosis)	Incorrect data can cause administrative denials.
Current Documents to Include	Ensure each item is current and clearly labeled. • Clinical notes • Prescriptions/orders • Plan of Care (POC) • Relevant imaging • Relevant orders • Test results (e.g., labs, sleep studies) • Requested service codes (CPT/HCPCS) • Correct provider identifiers (NPI/TIN)

For more than 20 years, Wellcare has offered a range of Medicare products, which offer affordable coverage beyond Original Medicare. If you have any questions, please contact Provider Relations.



By Allwell
By Fidelis Care
By Health Net
By 'Ohana Health Plan

General Prior Auth Checklist (Applies to All Requests)

Item	Notes
Complete Initial Request Information	Include clear description of services requested and supporting rationale.
Recent Clinical Documentation	Provide notes/clinicals within the last 90 days where applicable.
Orders and Plan of Care	Signed provider order and current/last visit note/POC as appropriate.
Relevant Testing & Imaging	X-ray, CT, MRI, labs, sleep study results, etc., as pertinent.
Medication List	Include current medications related to the request.
Applicable Codes	All relevant CPT/HCPCS codes; clarify purchase vs. rental when applicable.
Member Identifiers	Label all documents with member name and DOB; ensure accuracy and legibility.
Provider Identifiers	Correct NPI/TIN; ensure servicing and ordering provider information is complete.
Submission Quality	Avoid duplicate pages; ensure documents are complete, legible, and organized.
Recent Clinical Documentation – Details	Include History & Physical (H&P), specialist consult reports, lab results, and outcome tracking where relevant.
Objective Deficits Context	Document objective deficits with context (e.g., language background; bilingual assessment where applicable).
Face-to-Face Chart Notes	Ensure chart notes reflect face-to-face encounters between the patient and provider.
Clinical Records with Request	Send clinical records with the request (not just the request form).

Service-Specific Tables



Durable Medical Equipment (DME) Requests

Scenario	Required Documentation																
General DME – Initial Request Clarify rental vs. purchase up front; submit all documents in one packet; ensure justification links to functional needs; include quotes/orders for replacements vs. repairs.	Signed MD/PA order; HCPCS codes; servicing provider NPI/TIN; purchase vs. rental; itemized bill with codes & price; quantity; DOS range; member-specific medical justification; relevant imaging/exams; education completed on equipment.																
General DME – Ongoing/Continuation Provide objective improvement/benefit; include compliance where applicable; date notes within required windows.	Re-evaluation/Face-to-Face note; documentation of benefit/ongoing need; recommendation to continue use.																
Oxygen Equipment Align testing dates with recert cycles; include all lab results and physician interpretation.	New order and re-evaluation within last 90 days; repeat blood gas test within 60–90 days of recertification.																
Medicare:																	
<table><tr><th>Group</th><th>Oxygen Levels</th><th>Initial Coverage</th><th>Recertification Required</th></tr><tr><td>Group 1</td><td>PO₂ ≤55 or SpO₂ ≤88%</td><td>Long-term</td><td>✗ No routine retesting</td></tr><tr><td>Group 2</td><td>PO₂ 56-59 or SpO₂ ≤89% + condition</td><td>Limited</td><td>✓ Day 61–90 retest</td></tr><tr><td>Group 3</td><td>No hypoxemia; special condition</td><td>Short-term</td><td>✓ Day 61–90 retest</td></tr></table>	Group	Oxygen Levels	Initial Coverage	Recertification Required	Group 1	PO ₂ ≤55 or SpO ₂ ≤88%	Long-term	✗ No routine retesting	Group 2	PO ₂ 56-59 or SpO ₂ ≤89% + condition	Limited	✓ Day 61–90 retest	Group 3	No hypoxemia; special condition	Short-term	✓ Day 61–90 retest	
Group	Oxygen Levels	Initial Coverage	Recertification Required														
Group 1	PO ₂ ≤55 or SpO ₂ ≤88%	Long-term	✗ No routine retesting														
Group 2	PO ₂ 56-59 or SpO ₂ ≤89% + condition	Limited	✓ Day 61–90 retest														
Group 3	No hypoxemia; special condition	Short-term	✓ Day 61–90 retest														
CPAP Purchases/Continuation (OSA) Submit compliance downloads; specify payer rules in request; ensure evaluations fall within payer-specific timelines.	In person clinical evaluation by practitioner prior to sleep test to assess for OSA; sleep study results; re-evaluation within last 90 days; compliance report. Medicare: For CPAP equipment, Medicare follows a 13-month rent-to-purchase model. This includes an initial three-month trial period, followed by a 10-month rental period that converts to purchase.																
Wheelchair Requests Include ATP/vendor details where applicable; document home barriers; distinguish replacement vs. repair with quotes.	Age of chair; home assessment; trial of wheelchair; member’s ability to use; caregiver support; current mobility assessment; statement that needs cannot be met with lower-level devices.																
DME – Additional Requirements Ensure clarity and completeness in submissions. • Provide education completed on equipment (training/usage instruction). • Align documentation with payer-specific medical necessity criteria.	Additional documentation may be required depending on payer and policy. • Certificate of medical necessity (when required by benefit/policy). • Compliance reports for devices beyond CPAP (e.g., ventilators) • Home assessments for hospital beds (environment and safety)																

Genetic Testing Requests

Scenario	Required Documentation	Best Practices
All Genetic Testing – Initial	Ordering physician clinical notes; family history; prior genetic testing & results; tissue/biopsy date (if applicable); panel name; GTU code for processing; presumptive test results (if available); explanation of how results will impact care.	Include Concert Genetics* GTU code; clearly link test to clinical decision-making; label all pages with member information. *For plans that have not adopted Concert Genetics, a signed order is required for each test being ordered.

Therapy Requests (PT/OT/ST)

Scenario	Required Documentation	Best Practices
Initial Request	State-required documents; signed physician order/referral; valid therapy POC; initial evaluation; recent clinical notes/exams/images; POC with short- and long-term goals; all applicable CPT codes; number of prior visits.	Use objective measures to support need; provide brief clinical history; ensure documents are dated, signed, and legible.
Ongoing/Continuation	Progress notes with updated objective measures (daily notes not sufficient); functional progress; HEP compliance; assessment tools (scored/dated); updated frequency/duration; goal status explaining why skilled therapy remains necessary. • Include standardized scores where applicable. • Assessment tools should be scored, dated, and include the patient's name.	Summarize progress since start; quantify improvements; align requested frequency with demonstrated need.

Home Health & Community Intervention Services (CIS) Rehab

Scenario	Required Documentation	Best Practices
Initial/Start of Care	• State-required documents and providers' signatures, including current, completed plans of care. • Doctor's orders, signed plan of care, and supporting documents explaining the need for services. • Submission of Form 485 (for Home Health). • Medical records within the last 90 days (for CIS Rehab).	Provide clear goals and disciplines requested; include homebound status (if applicable).

Scenario	Required Documentation	Best Practices
EVV & Scheduling Specifics	Instructions for EVV units; avoid advance PRN requests; submit additional visits with proper documentation; scheduling constraints for private duty nursing with actual hours needed.	Detail caregiver availability; include school status (pediatrics); specify start/end dates and frequency per discipline.
Ongoing/Recertification	Updated plan of care, OASIS, recent clinical notes; therapy continuation requests with goals and progress; CPT codes, frequency, start/end dates; discharge plans. • Include estimated length of stay (LOS) and estimated discharge date.	Ensure legible and complete documentation; explain skilled nursing needs and care hours; align EVV compliance. • Provide detailed schedules and functional limitations to support accurate service planning. • Document reasons for home-bound status and frequency per discipline.
Special Requirements & Forms	Nutritional supplements/TPN specifics; AHCA forms for pediatric home care (if applicable); benefit exception forms; assistive technology/home assessments. • Assistive Technology Professional (ATP) details when mobility equipment is involved.	Include ATP details for mobility equipment; clarify variable hour requests and non-school days as needed.

Contact & Resources

For questions, please contact Provider Services or your Provider Engagement Administrator. Use the provider portal for prior authorization submissions when available. State-specific forms and policies may apply; refer to your plan's prior authorization resources.

If not using the provider portal, submit the plan-specific Prior Authorization Form.

For more detail, refer to Genetic Testing and DME-specific tip sheets (if available).



Prior Authorization Submission Quick Reference Checklist

Before submitting your Prior Authorization request, please confirm the following items are included and complete:

Member & Provider Information

- ☐ Member name and date of birth clearly labeled on all documents
- ☐ Correct servicing and ordering provider NPI and TIN
- ☐ Accurate provider contact information (phone/fax, etc.)
- ☐ Diagnosis code

Request Details

- ☐ Clear description of the requested service(s)
- ☐ All applicable CPT/HCPCS codes included
- ☐ Dates of service clearly identified
- ☐ Rental vs. purchase clearly indicated (if applicable)

Clinical Documentation

- ☐ Recent clinical notes (generally within the last 90 days, where applicable)
- ☐ Signed provider order or prescription
- ☐ Current Plan of Care (POC), if required
- ☐ Relevant imaging, lab results, testing, or specialist notes
- ☐ Documentation supports medical necessity for the requested service

Submission Quality

- ☐ Documents are legible, organized, and clearly labeled
- ☐ Duplicate or unnecessary pages removed
- ☐ Face-to-face encounter documentation included when required
- ☐ All required documents submitted together in one packet

Final Check

- ☐ Prior Authorization Request form completed in full
- ☐ Checklist reviewed prior to submission
- ☐ Submission sent through the appropriate portal, fax, or submission method for your plan/state