WELLCARE SUPERIOR HEALTH PLAN
DUAL ALIGN (HMO D-SNP)
OUTPATIENT AUTHORIZATION FORM

TEXAS

All Part B Drug Requests: **Fax** 1-844-960-1785
Expedited Requests: **Call** 1-855-445-3572
Standard Requests: **Fax** 1-877-808-9368
Transplant Requests: **Fax** 1-833-589-1243
Behavioral Health Requests/
Medical Records: **Fax** 1-855-772-7079
Incontinence Supplies: **Fax** 800-690-7030

☐ Request for additional units. Existing Authorization _____ Units _____

For All Standard or Expediated Part B Drug Requests, please fax to 844-960-1785
For Standard requests, complete this form and FAX to the appropriate department Determination made as expeditiously as the enrollee's health condition requires, but no later than 3 business days after receipt of request.

For Expedited requests, Please Call 1-855-445-3572. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member ID*

Last Name, First

Date of Birth* (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI*

Requesting TIN*

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax*

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider

Servicing NPI*

Servicing TIN*

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Primary Procedure Code* (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date OR Admission Date* (MMDDYYYY)

Diagnosis Code* (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

End Date OR Discharge Date (MMDDYYYY)

Total Units/Visits/Days

OUTPATIENT SERVICE TYPE*

(Enter the Service type number in the boxes) _____

712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
249 Home Health
225 Home Meals
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
729 Neuropsychological Testing
410 Observation
997 Office Visit/Consult

794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
650 Radiation Therapy
201 Sleep Studies
790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy
212 Therapy Evaluation
993 Transplant Evaluation
724 Transportation
209 Transplant Surgery

Behavioral Health
512 BH Community Based Services
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy (IOP)
510 BH Medical Management
518 BH Mental Health /Chemical - Dependency Observation
519 BH Outpatient Therapy
530 BH Partial Hospitalization Program (PHP)
520 BH Professional Fees
522 BH Psychiatric Evaluation

DME
417 DME - Rental
120 DME - Purchase
Purchase Price

Are services needed for discharge planning? ☐ **YES** ☐ **NO**

422 Biopharmacy (Please fax to 1-844-960-1785)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.