Inpatient Authorization Request

FAX TO:			
Kentucky Medicaid: Fax 1-877-338-2996			
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	

SERVICING PROVIDER		
WellCare ID:	NPI/Tax ID:	
Facility Name:	Phone Number	Fax Number
Address	City, State, ZIP	

ADMISSION INFO
☐Preplanned Admission ☐Emergency Room Visit ☐Observation ☐Inpatient Admit ☐LTACH ☐SNF
Place of Service: ☐21 Inpatient Hospital ☐22 Outpatient Hospital ☐23 ER Hospital ☐31 Skilled Nursing Facility
Admission Date or Planned 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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