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: ☐Transplant Consultation ☐Transplant Evaluation ☐Transplant Listing ☐Actual Transplant		
Transplant Type: ☐Bone Marrow ☐Solid Organ ☐Islet Cell ☐Stem Cell: Allogeneic / Autologous (Circle One)		
Solid Organ Type:		
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).		