

***Precertification Request for: Durable Medical Equipment,
Skilled Home Care, Home Infusion, Pain Management,
Hyperbaric, Hospice, Dialysis and Chiropractic Care***

Fax: 877-244-1723; Phone: 833-731-2149

This form should only be used for those services listed above.

To prevent delay in processing your request, please fill out form in its entirety with all applicable information. All other precertification requests:

General fax: 800-964-3627; DSNP fax: 888-235-8468; MLTSS fax: 888-826-9762

Member information					
Full name:					
Wellpoint member ID:					
Address City, state, ZIP code:					
DOB:					
Contact phone:					
Additional member information:					
Referring provider	<input type="checkbox"/> Participating		<input type="checkbox"/> Nonparticipating		
Full name:					
NPI:		Provider ID:		TIN:	
Office contact name:					
Office phone:				Office fax:	
Address City, state, ZIP code:					
Specialty:					

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Page 2 of 3

Servicing provider		<input type="checkbox"/> Participating		<input type="checkbox"/> Nonparticipating	
Full name:					
NPI:		Provider ID:		TIN:	
Office contact name:					
Office phone:				Office fax:	
Address City, state, ZIP code:					
Specialty:			Continuity of care request: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Servicing facility		<input type="checkbox"/> Participating		<input type="checkbox"/> Nonparticipating	
Full name:					
NPI:		Provider ID:		TIN:	
Office contact name:					
Office phone:				Office fax:	
Address: City, state, ZIP code:					
Requested service (For type of service, check all that apply.)					
Date/date range of service:		From:		To:	
ICD-10-CM code(s):					
CPT® code(s) (or HCPCS code[s]) for outpatient services; include requested units:					
Type of service:	<input type="checkbox"/> Diagnostic study <input type="checkbox"/> Durable medical equipment <input type="checkbox"/> Home health <input type="checkbox"/> Home infusion <input type="checkbox"/> Hospice <input type="checkbox"/> Hyperbaric <input type="checkbox"/> Office visit <input type="checkbox"/> Outpatient <input type="checkbox"/> Pain management <input type="checkbox"/> Other _____				

Servicing provider	<input type="checkbox"/> Participating	<input type="checkbox"/> Nonparticipating		
Place of service:	<input type="checkbox"/> Ambulatory surgery center <input type="checkbox"/> Nursing facility	<input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Other _____	<input type="checkbox"/> Hospital health <input type="checkbox"/> Independent lab	
Contact phone:				
Additional member information:	<input type="checkbox"/> Routine	<input type="checkbox"/> Emergent	<input type="checkbox"/> Urgent	<input type="checkbox"/> Expedited

Disclaimer: Authorization is based on verification of member eligibility and benefit coverage at the time of service and is subject to Wellpoint claims payment policy procedures.