Wellpoint

Washington Prior Authorization Form

Washington | Medicaid

Fax numbers:

- Home Health, home infusion, and durable medical equipment requests: **844-528-3681**
- Outpatient therapy, bariatric, pain management, podiatry, and orthotics/prosthetics requests: **855-231-8664**
- Skilled nursing, inpatient rehabilitation, long-term acute care hospital requests: **855-225-9940**
- Other precertification requests: **800-964-3627** (or call **800-454-3730** for information)

☐ **Emergent/urgent:** Use for all non-elective **inpatient** admissions or **outpatient** services only when the service was urgent, emergent, or expedited. This is limited to instances where authorization decisions could seriously jeopardize the enrollee's life or health, or ability to attain, maintain, or regain maximum function.

To prevent a delay in processing, please complete this form in its entirety and submit all clinical information to support your request.

Today's date:	**Provider return fax:**	**Provider return phone:**
Member information		
First name:	Last name:	Member ID:
DOB:	Contact phone:	
Address:	City, state, ZIP:	
Additional member information:		
Referring provider	☐ **Participating** ☐ **Nonparticipating**	
Full name:	Specialty:	
NPI:	TIN:	Provider ID:
Contact name:	Office phone:	Office fax:
Address:	City, state, ZIP:	
Servicing provider	☐ **Participating** ☐ **Nonparticipating**	
Full name:	Specialty:	
NPI:	TIN:	Provider ID:
Contact name:	Office phone:	Office fax:
Address:	City, state, ZIP:	
Servicing facility	☐ **Participating** ☐ **Nonparticipating**	
Name:		
NPI:	TIN:	Provider ID:
Contact name:	Facility phone:	Facility fax:
Address:	City, state, ZIP:	

Requested service	
Date/date range of service:	Number of units required:
ICD-10 code(s):	
CPT® codes and units requested:	
For outpatient therapy, the number of *units* used on current authorization:	
For outpatient therapy, the date of the member's last session:	
Type of service	
☐ Diagnostic study ☐ DME ☐ Home Health ☐ Hospice ☐ Inpatient **(Mark all that apply):** ☐ LTC/LTSS ☐ Observation extension ☐ Office visit ☐ Outpatient ☐ Personal care services ☐ Skilled nursing facility ☐ Other: _____	
Place of service	
☐ Ambulatory surgery ☐ Home ☐ Hospital ☐ Independent lab ☐ Nursing facility ☐ Office ☐ Other: _____ Additional information: _____ **If this is a request for extension or modification of an existing authorization, provide the authorization number:** _____	

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