Prior Authorization Request Form

For Medical Procedures

MEMBER INFORMATION	
Name:	Gender (Circle One): M F
DOB:	Other Insurance:
Member ID:	

PROVIDER INFORMATION	
Name:	NPI:
Tel:	Specialty:
Fax:	Address:
Contact Person:	

REQUIRED CLINICAL INFORMATION	
Diagnoses (List ICD-10 Codes and Description)	
1)	3)
2)	4)
Additional:	
Procedure(s) Requested (List all CPT/HCPCS Codes and Descriptions)	
1)	4)
2)	5)
3)	6)
Date of Service:	

Please attach supporting clinical information, which should include if available:

- ✓ Medical Records
- ✓ Lab Reports
- ✓ Progress Notes
- ✓ Diagnostic Studies
- ✓ Referrals
- ✓ Plan of Care

Please note: Determination of medical necessity will be made within three business days of receiving this form and all necessary information. There may be a delay if additional information is needed.

Completed form and all supporting documentation may be submitted to Wellfleet via fax or email:
Fax: 413-781-1958 Email: priorauth@wellfleetinsurance.com