Today's Options® HMO
A WellCare Company

P.O. Box 18149
Austin, TX 78760-8149
Fax to: 1-800-349-3548

Authorization Request Form

Date:________________________________ IPDA/LPO________________________________

EXPEDITED REQUESTS ONLY: This area is stating justification of **Medical Necessity of an Expedited Determination ONLY**. An EXPEDITED determination would be **requested if the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function:**

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Patient Name:	DOB:	PCP:	
Member ID#:		Member Phone #:	
Member Address:	City:	State:	Zip:
Referral Type: ☐ Inpatient Admit ☐ Outpatient Surgery ☐ Home Health (SN/ST/PT/OT) ☐ DME ☐ OP Therapy (ST/PT/OT) ☐ Office Visit ☐ Observation ☐ Other:			
Diagnostic Procedure/Testing:			
Referring Physician:	Specialty:		
Address:	City:	State:	Zip:
Phone #:	Fax #:		
Contact Person:			
Requested Provider/Facility:	Phone #:	Fax #:	
Address:	City:	State:	Zip:
If Referring Out-of-Network Please State Reason:			
Requested Procedure Description:			
CPT Code:	Requested Procedure Date:		
Additional Procedure(s):	CPT Code(s):		
Primary Diagnosis/Rule Out:	Date of Last Office Visit:		
Secondary Diagnosis(es):			
Primary Diagnosis/Rule Out:	ICD – 10 Code:		
Secondary Diagnosis(es):	ICD – 10 Code(s):		

PLEASE INCLUDE CLINICAL DOCUMENTATION WITH REQUEST

Send Claims to: Today's Options
P.O. Box 18500
Austin, TX 78760-8500

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