Fax to #281-626-9437

Phone: 800-830-6806
After Hours Phone: 713-906-4637
EZ Net Portal: https://eznet.innovistaportal.com

Authorization Request Form

Date: ______________________

This request will be treated as per the standard organization determination time frames. **If the request needs to be treated as expedited, please provide justification** that applying 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:		
Member ID No.:		Member Phone No.:	
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 **Non Emergency Ambulance Transportation**

Diagnostic Procedure/Testing: **n/a**

Requesting Physician:	WellCare Provider ID No.:		
Address:	City:	State:	ZIP:
Phone No.:	Fax No.:		
Contact Person:			
Treating Provider/Facility: **Acadian Ambulance Service of Texas**	WellCare Provider ID No.: **991538**	Phone No.: **337-521-3560**	
Fax No.: **337-291-2291**	Address: **3720 Corley Ave.**	City/State: **Beaumont, TX**	ZIP: **77701**
If Referring Out-of-Network, Please State Reason:			

Requested Procedure Description:	
CPT Code:	Requested Procedure/Admit Date:
Additional Procedure(s):	CPT Code(s):
Primary Diagnosis	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****

ALL REFERRALS FOR HMO PLAN MEMBERS MUST BE MADE TO CONTRACTED PROVIDERS

ALL LABWORK MUST BE SENT TO: Quest Diagnostics or other in-network lab provider.

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