**Home Health, Home Hospice and Inpatient Hospice Authorization Form**
**Fax completed form to: 608-252-0863**

| PATIENT DEMOGRAPHICS | | |
|---|---|---|
| Patient Name: | | Date of Birth: |
| Member ID: | | Phone Number: |
| Street Address: | | |
| City: | State: | Zip Code: |

| REFERRING PROVIDER INFORMATION | | |
|---|---|---|
| Provider Name: | | Phone #: |
| Street Address: | | Fax #: |
| City: | State: | Zip Code: |
| Provider #: | Specialty: | |

| REFERRED TO PHYSCIAN/FACILITY/PROVIDER INFORMATION | | |
|---|---|---|
| Referred To: | | Phone # |
| Street Address: | | Fax # |
| City: | State: | Zip Code: |
| Specialty: | | |

| REQUEST INFORMATION | | | | |
|---|---|---|---|---|
| ☐ Home Health | ☐ Home Hospice | ☐ Inpatient Hospice | | |
| Date (s) of Service: | Diagnosis Code(s): | ICD Code(s): | | |
| CPT Codes and Description: | | | | |
| # of Visits | 3rd party liability: | ☐ W/C | ☐ MVA | ☐ Other |

| Services Requested: |
|---|
| |

| Form Submitted By: | | |
|---|---|---|
| Name: | Phone: | Fax: |

For further information on hospice services, please see the WellFirst Health medical policy at wellfirstbenefits.com

The completed form can be faxed to: 608-252-0863
If you have any questions regarding the services or form, please contact our Customer Care Center at 866-514-4194 or review wellfirstbenefits.com Requests to non-plan providers must be approved prior to obtaining services.

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