Inpatient Authorization Request

FAX TO: MEDICARE		
All States Medicare: Fax 1-855-776-9464		
Requestor's Name: James Sherer	**Fax:** 19313212008	**Phone:** 6158671001
MEMBER		
WellCare ID:	**Last Name:**	**First Name, MI:**
Medicaid/Medicare #:	**Phone Number:**	**Date of Birth:**
REQUESTING PROVIDER		
WellCare ID : 890419	**Provider/Facility Name:** Med Stat Ambulance LLC	
Addres: PO BOX 331045	City, State, ZIP Murfreesboro, TN 37133	
Phone: 6158671001	Fax: 19313212008	NPI/Tax ID: 1649510918
SERVICING FACILITY		
WellCare ID:	NPI/Tax ID:	
Facility Name:	Phone Number	Fax Number
Address	City, State, ZIP	
SERVICING PROVIDER		
WellCare ID: 890419	NPI/Tax ID: 1649510918	
Facility Name: Med Stat Ambulance LLC	6158671001	Fax Number 19313212008
Address PO BOX 331045	City, State, ZIP Murfreesboro, TN 37133	

ADMISSION INFO

☐Preplanned Admission ☐Emergency Room Visit ☐Observation ☐Inpatient Admit ☐LTACH ☐SNF

Place of Service: ☐21 Inpatient Hospital ☐22 Outpatient Hospital ☐23 ER Hospital ☐31 Skilled Nursing Facility

Admission Date or Planned Admission Date: ___/___/_____ Requested length of stay: _____ days

Primary **ICD-10** Code: ___________ **Description**:_________________________________

Primary **CPT-4** Code A0425, A0428 **Description**: Ambulance service BLS milage

Please include additional procedures codes, as applicable, in the Clinical Summary below.

Pertinent Clinical Summary: (Attach supporting clinical records, if necessary).

Ambulance transport

PRO_28363E Internal Approved 12202018 NA8WCMFRM28363E_0000

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