Welbe Health

Authorization Request Form

For all authorization requests, please fax this completed form and clinical documentation to **(209)-729-5854**

For any questions regarding this authorization, scheduling, or verification of In Network Providers, please contact:
Telephone: (650)-336-0300 or **Email**: WelbeHubRequest@welbehealth.com

Market

- ☐ Coastline (LAC): 1220 E. 4th Street Long Beach, CA 90814 | Clinical Notes Fax: (855) 712-7837
- ☐ Sierra PACE (STN): 582 E. Harding Way Stockton, CA 5204 | Clinical Notes Fax: (844) 548-3818
- ☐ Pacific PACE (PAC): 50 Alessandro Pl. a20, Pasadena, CA 91105 | Clinical Notes Fax: (855) 245-2961
- ☐ Sequoia PACE (SEQ): 1649 Van Ness Ave, Fresno, CA 93721 | Clinical Notes Fax: (833) 963-2082

Type of Request

☐ New ☐ Post Service ☐ Modification

If this request is to modify an existing authorization, please provide authorization #:

_____

Urgency

Requests submitted as an urgent referral when standard timeframes could seriously jeopardize the participant's life or health or ability to attain, maintain or regain maximum function

☐ Urgent ☐ Routine

Member Information

Full Name:

Date of Birth:

ID Number:

Servicing Provider/Referred To

***Required if requesting services will be authorized to someone other than referring**

☐ MD ☐ Vendor ☐ Lab ☐ Facility ☐ Other

Name:

Address:

Phone:

NPI:

Referring Provider

Full Name:

Specialty:

Requesting Office Information

Contact:

Phone: ***Ext.***

Fax:

Place of Service

☐ ASC ☐ Long Term Care ☐ In - Office ☐ Home Visit

☐ Home Care Agency ☐ Outpatient Hospital ☐ Inpatient Hospital

☐ Other (Explain):_____

Date of Service and Location address (if scheduled):

Please enter all codes requested with a description:

ICD-10 Primary Dx Code:

ICD-10 Additional Dx Code (s):

CPT/HCPCS Code (s):

CPT/HCPCS Code Description:

# of Units being requested:

☐ Hours ☐ Days ☐ Months ☐ Visits ☐ Dosage

If applicable:

Service Start Date:

Service End Date:

Patient Clinical Information Needed

History and physical and/or consultation notes including:

Clinical findings (i.e., pertinent symptoms and duration)	Prior conservative treatments, duration, and response
Comorbidities	Past and present diagnostic testing and results
Activity and functional limitations	Treatment plan (i.e., surgical intervention)
Family history if applicable	Consultation and medical clearance report(s), when applicable
Reason for procedure/test/device, when applicable	Radiology report(s) and interpretation (i.e., MRI, CT, discogram)
Pertinent past procedural and surgical history	Laboratory results