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

- ☐ Carson (CAR): 20920 Chico Street, Carson, CA 90746 | Clinical Notes Fax: (833) 973-3630
- ☐ Coachella Valley (CVY): 46805 Dune Palms Rd, La Quinta, CA 92253 | Clinical Notes Fax: (833) 450-5964
- ☐ Long Beach (LAC): 1220 E. 4th Street, Long Beach, CA 90814 | Clinical Notes Fax: (855) 712-7837
- ☐ Modesto (MOD): 1224 Scenic Drive, Modesto, CA 95350 | Clinical Notes Fax: (833) 573-2336
- ☐ North Hollywood (NOH): 11633 Victory Blvd. Ste 100, North Hollywood, CA 91606 | Clinical Notes Fax: (833) 471-5322
- ☐ Pasadena (PAC): 50 Alessandro Pl. A20, Pasadena, CA 91105 | Clinical Notes Fax: (855) 245-2961
- ☐ Riverside (RIV): 2799 Gateway Drive, Riverside, CA 92507 | Clinical Notes Fax: (833) 450-5967
- ☐ Rosemead (ROS): 8399 Garvey Ave, Rosemead, CA 91770 | Clinical Notes Fax: (833) 471-4510
- ☐ San Jose (SJC): 1799 Hamilton Ave, San Jose, CA 95125 | Clinical Notes Fax: (833) 449-4676
- ☐ Fresno (SEQ): 1649 Van Ness Ave, Fresno, CA 93721 | Clinical Notes Fax: (833) 963-2082
- ☐ Stockton (STN): 582 E. Harding Way, Stockton, CA 95204 | Clinical Notes Fax: (844) 548-3818

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:

Place of Service

☐ ASC ☐ Home Care Agency ☐ Long Term Care
☐ In-Office ☐ Home Visit ☐ Inpatient Hospital
☐ Other (explain): _____ ☐ Outpatient Hospital

Date of Service and Location address (if scheduled):

Requesting Office Information

Contact:
Phone: ***Ext.***
Fax:

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