Welbe Health

Authorization Request Form

For quicker processing, submit this authorization request online at: https://welbehealth.quickcap.net/

Alternatively, fax the completed form along with 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

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:

Emergency, preventive, sexually transmitted disease services and HIV testing do not require authorization.

ICD-10 Primary Dx Code:
ICD-10 Additional Dx Code(s):
CPT/HCPCS Code(s):
CPT/HCPCS Code Description(s):

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