Preferred Care Partners

Prior Authorization Form

(Palm Beach Only) -Referral Number _____

INSTRUCTIONS: Services requested must be authorized PRIOR TO SCHEDULING THE PATIENT.
Requesting provider must complete and sign this form.
Fax the form to the Utilization Management department at: **(305) 670-2166** or **(866) 567-0144.**
For additional services not listed on this form, and for all other questions, contact us at **(800) 995-0480.**
Authorizations are approved and eligible for reimbursement pending CMS verification of eligibility and benefits on the date of service. The Referral Section is only for Palm Beach Providers Only

For a member who is assigned to a Preferred Care Partners Medical Group Primary Care Physician and WellMed is referenced on the bottom right side of the member ID card, submit this form to WellMed Medical Management at 866-322-7276

Patient Information

PATIENT NAME	DATE OF BIRTH	MEMBER ID #

Requesting Provider Information

PROVIDER NAME	SPECIALTY □ PAR □ NON-PAR	TELEPHONE
ADDRESS (STREET, CITY, STATE, ZIP)		FAX

Primary Care Physician Information

PHYSICIAN NAME	TELEPHONE	FAX

Referral Information

REFERRED TO PROVIDER NAME	☐ PAR ☐ NON-PAR	TELEPHONE
ADDRESS (STREET, CITY, STATE, ZIP)		FAX

Diagnosis/Complaints

COMPLAINT/SYMPTOMS	
DIAGNOSIS DESCRIPTION	ICD10 CODES

Services Requested

PROCEDURE	CPT CODE	PROCEDURE	CPT CODE
ADDITIONAL COMMENTS		DATE OF SERVICE	NUMBER OF VISITS REQUESTED
		REQUESTING PHYSICIAN SIGNATURE (**REQUIRED**)	

For PREFERRED CARE PARTNERS Use Only

PCC COMMENTS			
MEDICAL DIRECTOR DETERMINATION	☐ **APPROVED** ☐ **DENIED**		
REASON FOR DENIAL			
MEDICAL DIRECTOR'S SIGNATURE		DATE/TIME	PCC/CM
AUTHORIZATION #	STATUS	ISSUE DATE	EXPIRATION DATE