Medical Management Department
8735 Henderson Road Ren. 2
Tampa, Florida 33634
Outpatient services: Fax 1-800-246-7983
Inpatient services: Fax 1-877-431-8860

REFERRAL FORM

Member name: (Last)_____(First)_____(MI)_____
☐ M ☐ F Date of Birth _____/_____/_____Member #: _____
PCP Name:_____ Fax #: (___) ___-_____
Diagnosis Code (ICD-9) and Description: _____
Current Medications: _____
Drug Allergies:_____

INFORMATION ON PROVIDER TO WHOM YOU ARE REFERRING
Provider name: (Last) _____(First)_____
Specialty: _____Provider ID#: _____
Address: _____ Phone: (___) _____
_____ Fax: (___) _____
Number of Office Visits: _____
(Not to exceed three (3) except for dialysis, outpatient chemotherapy, or radiation therapy.)
☐ Dialysis* ☐ Outpatient Chemotherapy* ☐ Radiation therapy*
☐ Emergency room visit (must be submitted within 48 hours of ER visits)
*Visits for the above services will be given in accordance with WellCare's Clinical Practice guidelines. These guidelines can be obtained by either referencing your Provider Manual or by calling WellCare's Medical Management Department.

_____ _____
Physician Signature Date of referral

IMPORTANT NOTICE:
MESSAGE TO SPECIALIST PHYSICIAN (PROVIDER):

1. This referral is for consultation, diagnostics, and/or treatment. After your consultation you must contact the Primary Care Physician regarding your findings. Please note that certain procedures or treatments performed on WellCare members require authorization by WellCare's Medical Management Department. To obtain authorization for required procedures/treatments or information regarding which procedures/treatments require authorization, please call 800-421-1755, option 4.
2. This referral is valid for up to three (3) visits within 60 days. Any referral to you for further services is not covered unless authorized by the Primary Care Physician in advance.
3. Acceptance of this referral binds the provider of care to the terms and conditions of an applicable provider agreement.
4. A referral form for services does not guarantee payment and is only valid for eligible WellCare members at the time of service .
5. All services must be medically necessary and covered benefits under the member's contract.

MESSAGE TO THE WELLCARE MEMBER

1. This form authorized only those visits indicated above. If services are obtained without appropriate authorization, claims can be denied in accordance with your member contract and you may be responsible for payment.