

**FAX TRANSMITTAL
COVER SHEET**



PFFS Advanced Coverage Determination

From: To: PFFS Advance Coverage Determination

Fax: Fax: 1-813-464-8764

Phone Number:

Pages: (including cover page)

Subject: PFFS Advance Coverage Determination

WellCare PFFS will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member’s request or WellCare PFFS justification that the delay is in the member’s best interest. In cases where you believe that waiting for a decision under this time frame could place the member’s life, health or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, call us at 1-866-235-2770 or check the box at the bottom of this form. For expedited determinations, we will notify you of our decision within 72 hours.

Please provide the following information:

| Member | |
|--|--|
| Member Plan ID: | Today’s Date: |
| Member Last Name: | Member First Name: |
| Member Phone Number: | Date of Birth: |
| Requesting Provider | |
| Provider ID: | Type: PCP Specialist |
| Provider Last Name: | Provider First Name: |
| Phone Number: | Fax Number: |
| Address: _____ City: _____ State: _____ ZIP: _____ | |
| Phone Number: | Fax Number: |

Privacy Notice:

This facsimile message and any attachments are intended for the exclusive use of the addressee(s) and may contain information that is proprietary, confidential and/or exempt from disclosure and may be Protected Health Information. If you are not the intended recipient, please notify us immediately by calling the number below and return the original message to us at the address below via the US Postal Service. We will reimburse you for your postage. If you are a regular recipient of our faxes, please notify us if you change your fax number. Thank you.

WellCare Health Plans, Inc.
Attention: Chief Privacy Officer
8735 Henderson Road, Ren. 2
Tampa, FL 33634
Phone: (813) 290-6200

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| Facility | | | |
|--|--------------------------------------|--------------------|----------------------------------|
| Place of Service: | Office/clinic | OP Hospital | Free Standing Facility Home |
| Facility ID: | | Facility Name: | |
| Address: _____ | | City: _____ | State: _____ ZIP: _____ |
| Phone Number: | | Fax Number: | |
| Service Requested | | | |
| Planned Date of Service: From: ___/___/___ To: ___/___/___ | | | |
| Primary ICD-9 Code: | | Description: | |
| CPT- 4 / HCPC Code | Description of Procedure or Services | Visits / Frequency | |
| | | | |
| | | | |
| | | | |
| Please include additional procedure codes, as applicable, in the Clinical Summary below. | | | |
| Pertinent Clinical Summary: (Attach supporting clinical records, if necessary). For customized equipment or services, specify pertinent member information (i.e., height, weight, O ₂ saturation, sleep study, functional assessment, etc.) | | | |
| | | | |
| | | | |

Expedited Review (*Defined as medically necessary treatment for an injury, illness, or other type of condition—usually not life threatening—which should be treated within 24 hours.*)

Provider Service Center: 1-866-235-2770 (TTY/TDD: 1-866-239-6265) Monday–Sunday, 7am to 2am Eastern

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