Wellfleet Retrospective Review Authorization Form

For use when no state specific form available

Applicable Services:

- **THERAPIES PERFORMED BY OUT-OF-NETWORK PROVIDERS**
- **GENDER AFFIRMING SERVICES**

Do not use this form: 1) to request an appeal, 2) to confirm eligibility, 3) to verify coverage, 4) to ask whether a service requires prior authorization, 5) to request prior authorization of a prescription drug, 6) for services that require precertification other than those listed above, or 7) to request a referral to an out of network physician, facility, or other health care provider.

To file via facsimile, send to: **[413-781-1958]**

To file via secure email: Set up login at wellfleet-mail.com and register for secure submittal via Zix. Send requests to: priorauth@wellfleetinsurance.com**.**

For further information or questions, please call the phone number listed on the back of the customer's ID card or call Customer Service team (800)633-7867.

PLEASE NOTE: Determination of medical necessity will be made in an expedited manner upon receipt of this form and all necessary information.
There may be a delay if additional information is needed. Wellfleet may utilize independent review organizations. *Wellfleet utilizes utilization management (UM) vendors for services that require pre-certification, separate from the "Applicable Services" noted at the top of this form. Clinical review criteria and information on how to submit pre-certification requests to UM vendors may be found https://wellfleetstudent.com/forms.

WELLFLEET

RETROSPECTIVE REVIEW
FOR MEDICAL NECESSITY

Applicable Services:

- **PT/OT/CHIRO PERFORMED BY OUT-OF-NETWORK PROVIDERS**
- **GENDER AFFIRMING SERVICES**

Do not use this form: 1) to request an appeal, 2) to confirm eligibility, 3) to verify coverage, 4) to ask whether a service requires prior authorization, 5) to request prior authorization of a prescription drug, 6) for services that require precertification, or 7) to request a referral to an out of network physician, facility, or other health care provider.

MEMBER INFORMATION	
Legal Name:	Preferred Name (if different):
DOB:	Address:
Member ID:	Phone/Email:
GENERAL INFORMATION	
REVIEW TYPE: NON-URGENT ☐	URGENT ☐
Clinical Reason for Urgency:	
PROVIDER INFORMATION	
Referring/Requesting Provider Information	**Rendering/Attending Provider Information**
Name:	Name:
Practice Name:	Practice Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
Email:	Email:
REQUIRED CLINICAL INFORMATION	
Date of Request:	**Type of Service:**
Dates of Services:	
Diagnoses (List ICD-10 Codes and Descriptions)	3)
1)	4)
2)	5)
Additional:	
Procedure(s) Requested (List all CPT/HCPCS Codes)	4)
1)	5)
2)	6)
3)	7)
Additional Clinical Information Attached: ☐	Number of Pages:

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Completed form and all supporting documentation may be submitted to Wellfleet via fax (413-781-1958) or email priorauth@wellfleetinsurance.com.