Rhode Island Medical Prior Authorization Form

Applicable Services:

Wellfleet utilizes utilization management (UM) vendors for services that require pre-certification. Clinical review criteria and information on how to submit pre-certification requests to UM vendors may be found https://wellfleetstudent.com/providers/ under **Other Provider Resources**

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, or **6)** to request a referral to an out of network physician, facility, or other health care provider.

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

PLEASE NOTE: Determination of medical necessity will follow state specific turnaround times upon receipt of this form and all necessary information.
There may be a delay if additional information is needed.

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STUDENT

RHODE ISLAND PRE-SERVICE CLAIM FORM

INSTRUCTIONS: This form only applies to members of Student Health Insurance plans in Rhode Island. This form may be completed by the member/participant, authorized representative, or health care provider.[1] Please complete all applicable fields below. Fields marked with an asterisk (*) are required for the type of request being submitted. A benefit determination cannot be provided if these fields are not completed. Email the completed form to customerservice@wellfleetinsurance.com.

Member Name*	**Member Date of Birth***	**Participant Name (if dependent)**	**Participant Date of Birth (if dependent)**
Member ID Number*	**School Name***	**Group Number**	**Requestor's Email**

TYPE OF REQUEST: (CHECK APPLICABLE BOX)

☐ Non-Urgent ☐ Urgent (Requiring treatment within 24 hours)	☐ Medical Coverage ☐ Pharmacy Coverage ☐ Enrollment/Eligibility

FOR COVERAGE UNDER MEDICAL BENEFIT

Diagnosis code(s)*:		CPT/HCPCS code(s)*:	
Service(s) description*:			
Place of service*:	☐ Inpatient ☐ Outpatient	Date of service*:	
Provider Tax ID:		Provider/Facility Name*	
Is this request related to an intercollegiate sports injury?	☐ Yes ☐ No	Additional comments:	

FOR COVERAGE UNDER PHARMACY BENEFIT

Medication name*:		Medication strength*:	
Medication dosage form*:		Quantity*:	
Days supply*:		Additional comments:	

FOR ENROLLMENT / ELIGIBILITY DETERMINATIONS

Provide specific details on the request:

[1] A completed authorization form must be on file before your information can be released to a representative other than your health care provider.

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By signing this pre-service claim form, I acknowledge that I have read and understand this document. I certify that I have read all answers to this form, and to the best of my knowledge the information I have given is complete and true. Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty and the stated value of the claim for each violation.

*Requestor Name:*_____ *Relationship to member/participant:*_____

*Signature:*_____ *Date:*_____