

PATIENT DEMOGRAPHICS		
Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION		
Provider Name:		Phone #:
Street Address:		Fax #:
City:	State:	Zip Code:
Provider #:	Specialty:	

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION		
Referred To:		Phone #
Street Address:		Fax #
City:	State:	Zip Code:
Specialty:		

REQUEST INFORMATION				
Home Health	Home Hospice	Inpatient Hospice		
Date (s) of Service:	Diagnosis Code(s):	ICD Code(s):		
CPT Codes and Description:				
# of Visits	3 rd party liability:	W/C	MVA	Other

Services Requested:

Form Submitted By:		
Name:	Phone:	Fax:

For further information on hospice services, please see the WellFirst Health medical policy [Hospice Services](#).

The completed form can be faxed to: 608-252-0863

If you have any questions regarding the services or form, please contact our Customer Care Center at 866-514-4194 or visit wellfirstbenefits.com. Requests to non-plan providers must be approved prior to obtaining services.

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