

# IMPROVEMENTS HAVE BEEN MADE TO THE Medicare Request for Information Fax



To ensure a smooth prior authorization process and avoid delays in patient care, we have made updates to our Request for Information Fax.

The following is important information to look for within the updated fax:

## Fax Request for Additional Clinical Information to Establish Medical Necessity

} Letter Title



Authorization Number: 5236232  
 Member/Patient Name: NV PPO Test  
 Member/Patient DOB: 11/03/2019  
 Member Medicare ID Number:

} Member Identifiers

Dear

We have received and reviewed the authorization request for the above member for:

99221: INIT HOSP CARE-DA E&M LOW SEVERITY 30 MIN  
 on 07/16/2023 - 07/17/2023

However, additional information is needed to determine medical necessity and process the request.

Please FAX the information below no later than 4pm CST on 01/08/2026 to 999-999-9999 for immediate processing. Please include a copy of this form when returning the requested information. Failure to provide information may result in a delayed determination or inability to approve the authorization request.

The following documentation, including any clinical information or documents that support medical necessity (Title XIX form, test results, information about failed conservative treatment, etc.), are requested:

Time, Date, and Fax Number of when and where to send required documents to for clinical review

Boxes marked with an (x) indicate items that need to be submitted to the above fax number to complete the clinical review.

Clinical Notes	Report(s)	Clinical Information Specific to Procedure
<input type="checkbox"/> History and Physical <input type="checkbox"/> Face-to-Face Notes <input type="checkbox"/> Physician Referral <input type="checkbox"/> PT/OT/ST Notes	<input type="checkbox"/> Procedure Report (incl. prior) <input type="checkbox"/> Consultation Report <input type="checkbox"/> Lab and Imaging Report(s)	<input type="checkbox"/> Indication for the Specified Procedure <input type="checkbox"/> Comorbidities (if relevant) <input type="checkbox"/> Genetic Testing Results (if applicable) <input type="checkbox"/> Any Other Relevant Documentation <input type="checkbox"/> DME Type

If you have any further questions or concerns about this request, please contact Clinical Review Nurse Name at 999-999-9999 Monday – Friday from 8am-5pm CST. We appreciate your partnership in our members' care.

Sincerely,  
 The Utilization Management Team, Wellcare

Name, phone number and hours of the clinical reviewer

Submitting Prior Authorization requests via the secure Availity portal allows for faster review.

# Medicare Request for Information Fax



## EXAMPLE LETTER:

PO Box 31370  
Tampa, FL 33631-3370  
(855) 538-0454  
www.wellcare.com/medicare

### Facsimile Cover Sheet

To	Test	From	xi
Company	Test	Dept	UM Department
Fax	(999) 999-9999	Phone	(855) 538-0454
Subject	Wellcare Fax Request for Information	Fax	
# of Pages	[1 of 6]	Date	07/11/2025

Test - Send Documentation to 999-999-9999

**Confidential Health Information enclosed**

Confidentiality Notice: The documents accompanying this facsimile message may contain Protected Health Information or other information that is legally privileged or confidential. The information is intended only for the use of the designated recipient or entity named above. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error, and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you received this notification in error, please notify us immediately by telephone at (855) 538-0454 and return the original message to us by mail at PO Box 31370 Tampa, FL 33631-3370. Thank you.

Authorization is not a guarantee of benefits or payment. Payment of benefits is subject to any subsequent review of medical information or records, the patient's eligibility on the date the service is rendered and any other contractual provisions of the member's plan.

### Fax Request for Additional Clinical Information to Establish Medical Necessity

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**Member/Patient DOB:** 11/03/2019  
**Member Medicare ID Number:**

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