P.O. Box 81665
Austin, Texas 78708
Phone: (800) 580-2273
Fax: (800) 580-3123

Pre-Authorization Request
Fax Request to: 800-580-3123
Email: UR@wellcomp.com

Claimant Information			
Claimant Name:		**Social Security #:**	
Address:		**DOB:**	
City:		**Phone:**	
State, Zip			

Employer Information			
Employer Name:		**Phone:**	
Address:		**FEIN:**	
City:			
State, Zip			

Workers' Compensation Insurance Information			
Insurance Carrier:		**Claim Number:**	
Address:		**DOI:**	
City:		**Phone:**	
State, Zip		**Adjuster Name:**	

Requesting Provider			
Doctor Name:		**Phone:**	
Address:		**Fax:**	
City:		**Tax ID:**	
State, Zip		**NPI or License #:**	

Facility Where Services Will Be Provided (if applicable)			
Facility Name:		**Phone:**	
Address:		**Fax:**	
City:		**Tax ID:**	
State, Zip		**NPI or License #:**	

Requested Procedure/Services	
Procedure/Service:	
DX Code(s):	
CPT Code(s):	
Date of Service(s)	(*Date services expected to be rendered)*

Defense Attorney Information	
Name:	
Mailing Address:	
Phone:	
Fax:	

Applicant Attorney Information	
Name:	
Mailing Address:	
Phone:	
Fax:	

Are clinicals attached to support requested services? **_____ Yes** **____ No**

Is this an Appeal? **_____ Yes** **____ No**

Notes/Comments: