

Today's Date: _____

URGENT: Yes No

Fax to: 1-800-267-8328

MEMBER INFORMATION

Please Print

Patient Name: _____ Member ID#: _____
 Other Health Ins: _____ Male Female DOB: _____
 Home Address: _____
 City, State and ZIP Code: _____ Phone: _____

REFERRING PHYSICIAN INFORMATION

Physician's Name: _____ Specialty: _____
 Contact Name: _____ Phone #: _____
 Physician / Authorized Signature: _____ Fax #: _____

SERVICING PROVIDER INFORMATION

TIN _____ PAR/NON PAR _____ Does the NON PAR provider accept HI Medicaid rates? YES NO
 Provider's Name: _____ Specialty: _____
 Provider's Address: _____ Phone #: _____
 Office Contact Name: _____ Fax #: _____
 Service Setting (IP, OP, Office, other): _____ Facility Name: _____
 Date of Service: From: _____ To: _____ OR Pending Authorization
 PT / OT / Speech Therapy: Initial Request or Continuing: Last DOS: _____ PLEASE SPECIFY # of Visits: _____
 Requests for **continuation** of PT / OT / ST: Send initial and / or updated evaluation and progress notes along with physician's signature.

Reason for Request:

Please attach clinical notes / documentation of medical necessity for requested service:

*ICD-9 CODE(S)	**ICD-10 CODE(S)	*ICD-9 Codes are required for Date(s) of Service prior to 10/1/2015; **ICD-10 Codes are required for Date(s) of Service on/after 10/1/2015 Please do not use ICD-10: R69, ILLNESS UNSPECIFIED, as it is not an authorized code ENTER DIAGNOSIS DESCRIPTION (Below)	
CPT / HCPC CODE(S)	COST OF DME	PROCEDURE(S) / TREATMENT(S)	# OF VISIT(S) or UNIT(S) AND FREQUENCY (PER DAY, MONTH, OR YEAR)

Durable Medical Equipment (DME): Rental or Purchase (Must include MD's order and medical documents with DME cost)
 Transportation required: Yes No
 If Air transportation is being requested, please submit the AIR TRANSPORTATION REQUEST FORM together with this Prior Authorization request for Medical Services. Please submit routine transportation requests 14 days prior to the travel date.

Once approved, this notification is valid for the number of authorized visit(s), date(s) that are approved for the condition and only for the patient identified.
 NOTE: Coverage is dependent on member's eligibility and plan benefit at the time of service. Prior Notification Form (Rev. 7/15).