OUTPATIENT AUTHORIZATION REQUEST

949 Kamokila Boulevard, 3rd floor, Suite 350
Kapolei, HI 96707

Please Fax completed form to: **(888) 881-8225**
Customer Service Phone Numbers: **Medicare** (888) 505-1201 **Medicaid** (888) 846-4262

☐ Standard Request	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the health plan fourteen (14) days prior to the date the requested services will be performed.
☐ Expedited Request	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.
(MD Signature Required)	**Physician Signature Validating Expedited Request** _____ Date Signed _____

☐ Precertification Request ☐ Payment Determination Request ☐ Out of State / Out of Network

Contact Information

Identify whom to contact for any questions or concerns regarding this request:

Contact Name (Last, First) _____ Contact Phone Number _____ Contact Fax Number _____

Member Information

'Ohana ID Number _____ Member Name (Last, First , MI) _____ Date of Birth _____

Member Address _____ Member Phone Number _____

Service / Procedure / Treatment Information

Planned Date of Service: _____ to _____

ICD Dx Codes: _____ _____ _____ _____ _____ _____ _____

Place of Service: ☐ ASC Ambulatory Surgery Center ☐ Outpatient ☐ Office ☐ Home ☐ Other _____

CPT/HCPCS Code(s):

Code	# visits / units	Code	# visits / units	Code	# visits / units	Code	# visits / units
Code	# visits / units	Code	# visits / units	Code	# visits / units	Code	# visits / units

PT/OT/Aqua/Speech Therapy: ☐ Initial Request ☐ Continuing--Last DOS: _____ Total Visits Used: _____

Pregnancy Notification (Global OB Authorization): ☐ High Risk EDD: _____ 1st Prenatal Visit: _____

Provider Information

Requesting /Referring Provider Name _____ Provider ID _____ Provider Type _____

Provider Address (Including City/State/Zip Code) _____

Phone Number _____ Fax Number _____

Treating Provider Name _____ Provider ID _____ Specialty _____

Provider Address (Including City/State/Zip Code) _____

Phone Number _____ Fax Number _____

☐ Check this box to skip this section and have the Plan assign the Facility

Facility Provider Name _____ Facility ID _____ Facility Type _____

Facility Address (Including City/State/Zip Code) _____

Phone Number _____ Fax Number _____

Additional Information: i.e. Clinical Summary, Description of Request, Reason for referral to an Out of State/Out of Network Provider

Please attach supporting documentation to avoid delays.

*Authorizations will be given for medically necessary services only: it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergencies do not require prior authorization (An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result, without immediate medical attention, in serious jeopardy to the health of an individual). *Urgent Care is defined as medically necessary treatment for an injury, illness, or other type of condition (usually not life threatening) which should be treated within 24 hours.*