Hawaii authorization request for air transportation, lodging and meals

Urgent: ☐ Yes Today's date : Fax to 800-267-8328

Member information

Name (Last, First, Middle):		Member Plan ID#:
Gender:	Home street address: (Do not enter P.O. box):	
ZIP:	Phone:	Alternate phone:
Date of birth:	Contact person (Relationship):	Phone:

PCP information

PCP name:	Contact name:
Phone:	Fax:

Referring medical provider information

Name (Last, First, Middle):		Specialty:
Contact name:	Phone:	Fax:

Appointment information

Treatment/description of medical service: ☐ Consult ☐ Follow-up Other:

Medical reason for treatment (including diagnosis):

Reason for request (i.e., no specialist on island of residence, procedure cannot be done on island or residence, etc.)

Rendering physician:		Phone:
Specialty:	Start date mm/dd/yy:	Check-in time:

Appointment information (cont.)

End date mm/dd/yy:	End time:	
Physical street address:		
Island or state:	Facility:	
Additional appointment:	Rendering physician:	
Phone:	Specialty:	Start date dd/mm/yy:
Check-in time:	End date dd/mm/yy:	End time:
Physical street address:		
Island or state:	Facility:	

Travel request information:

Please attach clinical information to support any request to travel out of state.

Departure city/airport:	Arrival city/airport:	Departure date dd/mm/yy:
Return date dd/mm/yy:	Medical reason for stay longer than 1 day:	
Type of ticket: ☐ One-way ☐ Round-trip	Attendant required: ☐ Yes ☐ No	
Medical reason for attendant:		
Name of adult attendant (as listed on valid photo ID):		Gender:
Date of birth:	Ground transportation required: ☐ Home island ☐ Neighbor island ☐ Mainland ☐ Not required	
Do not use this field to indicate a need for airport W/C assistance Member provides W/C? ☐ Yes ☐ No What type? Able to transfer in/out of W/C? ☐ Yes ☐ No		
Meals Required: ☐ Yes ☐ No	Lodging Required: ☐ Yes ☐ No	
Oxygen Required: ☐ Yes ☐ No	If Yes: ☐ Nasal ☐ Mask ☐ O2	Flow Rate:

Comments

United Healthcare Community Plan