Prior Authorization Request Form

ALOHACARE ☐	hmsa ☐	'ohana health plan ☐	United Healthcare Community Plan ☐
Fax #: 808.973.0676 (Oahu) 888.667.0680 (NI) Phone #: 808.973.0712 Website: www.alohacare.org	Fax #: 808.944.5611 Phone #: 808.948.6464 (Oahu) 800.344.6122 (NI) 800.877.5394 (Mainland) Website: hhin.hmsa.com	Fax #: 888.881.8225 Phone # for Expedited: 888.505.1201 (Medicare) 888.846.4262 (Medicaid) Website: provider.wellcare.com	Fax #: 800.267.8328 Phone #: 888.980.8728 Website: www.uhcprovider.com

☐ **Standard request**	For Medicare and Medicaid plans: decision & notification are made within **7** calendar days* For HMSA Commercial, Federal and EUTF plans: decisions & notification are made within **15** calendar days*
☐ **Expedited request** *(MD, PA, RN, RD or LPN) Signature required)*	Decision & notification are made within 72 hours* or as expeditiously as this member's health condition requires if urgent criteria are met. *By signing below, I certify that following the standard timeframe could seriously jeopardize this member's life or health or ability to attain, maintain, or regain maximum function.* Signature *(if left blank, request will be reviewed based on standard timeframes)* Date signed
☐ **Retrospective**	Retrospective authorization is defined as a request for services that have been rendered but a claim has not been submitted.

**From receipt of request, provided that all relevant supporting clinical information and documentation are submitted.*

To avoid delays, please attach supporting documents

A. Member information

Membership ID Patient's Name **(Last, First** MI) Date of birth (MM/DD/YYYY)

Member's Physical Address Phone #

B. ICD-10-CM diagnosis code(s)

Diagnosis code(s): _____ _____ _____ _____

C. Procedure/service/treatment information

Place of service: ☐ Inpatient ☐ Outpatient/ASC (ambulatory surgical center) ☐ Labs and diagnostic (outpatient) ☐ Office ☐ Home

For Rehab Services (check one): ☐ PT ☐ OT ☐ Speech ☐ Initial ☐ Continuing Last Date of Service: _____ Total Visits Used: _____

CPT/HCPCS code(s)	Cost of DME	Modifier	# of units	CPT/HCPCS code(s)	Cost of DME	Modifier	# of units

Service date(s): _____ to _____ ☐ **Hospital Discharge**

D. Provider information

Requesting (or referring) provider name Provider NPI

Address

Contact Name **Phone No.** **Fax No.**

Servicing Provider/Facility/Vendor (if different from requesting or referring provider) Provider NPI

Address

Contact Name **Phone No.** **Fax No.**

E. General Comments