'ohana health plan™
820 Mililani Street, Suite 200
Honolulu, HI 96813

Outpatient Authorization Request and Physician Request for Transportation, Lodging, and Meals

Please fax completed form to:
1-888-881-8225

Customer Service Phone Numbers:
Medicare 1-888-505-1201 | **Medicaid 1-888-846-4262**

☐ **Standard Request**	Requests for prior authorization (with supporting clinical information and documentation) should be sent to 'Ohana Health Plan 7 days prior to the date the requested services will be performed.
☐ **Expedited Request** *(MD Signature Required)*	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. _____ _____ **Physician Signature Validating Expedited Request** Date Signed

☐ Precertification Request ☐ Payment Determination Request ☐ Out-of-State/Out-of-Network ☐ Off-Island Travel *(Complete Page 3)*

Contact Information

List 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:

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Internal Approved 11032025

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 ʻOhana 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.

Authorization 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.

Off-Island Travel Request Information

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Criteria:

- Member must have Medicaid or CCS with 'Ohana Health Plan.
- Appointments should be made for Monday through Thursday and no later than 2 p.m.

Member Name: _____ 'Ohana ID #:_____

Appointment Details Related to Travel

Treating Provider Address (if different from above):		
Date member must be present:	Start Time:	Additional Info:
Date of expected release:	End Time:	Additional Info:

Travel Details

Type of Request: ☐ Air ☐ Ferry	Type of Ticket: ☐ One-way ☐ Round-trip	Departure Date:	Return Date:
Departure City/Airport:		Arrival City/Airport:	To assure travel accomodations, please indicate Member's: Height: Weight:
Medical reason if stay is longer than one day:			
Lodging Required? ☐ No ☐ Yes		Meals Required? ☐ No ☐ Yes	

Attendant Information

Attendant Required? ☐ No ☐ Yes **If yes, will require additional 24 hours to process.*	Name & birth date of adult attendant: *(As Listed on Valid Photo ID)*
Medical Reason for Attendant:	

Ground Transportation

Ground Transportation Required? ☐ No ☐ Yes	Preferred Transportation Provider:
Needed on Home Island? ☐ No ☐ Yes	Needed at Treating Destination? ☐ No ☐ Yes

Medical Needs

Wheelchair Required? ☐ No ☐ Yes	Has own Wheelchair? ☐ No ☐ Yes If yes, type:	Oxygen required? ☐ No ☐ Yes If yes: ☐ Nasal ☐ Mask	O2 flow rate:
Other special travel needs:			

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