





Prior Authorization Request Form

 <p>Fax #: 808.973.0676 (Oahu) 888.667.0680 (NI) Phone #: 808.973.0712 Website: www.alohacare.org</p>	 <p>Fax #: 808.944.5611 Phone #: 808.948.6464 (Oahu) 800.344.6122 (NI) 800.877.5394 (Mainland) Website: hjin.hmsa.com</p>	 <p>Fax #: 888.881.8225 Phone # for Expedited: 888.505.1201 (Medicare) 888.846.4262 (Medicaid) Website: provider.wellcare.com</p>	 <p>Fax #: 800.267.8328 Phone #: 888.980.8728 Website: uhcprovider.com</p>
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<input type="checkbox"/> 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*
<input type="checkbox"/> Expedited request <i>(MD, PA, RN, RD or LPN) Signature required)</i>	Decision & notification are made within 72 hours* or as expeditiously as this member's health condition requires if urgent criteria are met. <i>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.</i>
<input type="checkbox"/> 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