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

TeleMedicine Authorization Request

Please Fax completed form to: **1-888-881-8225**

PRIORITY LEVEL		
☐	*Standard Request*	*Requests for prior authorization (with supporting clinical information and documentation) should be sent to 'Ohana 14 days prior to the date the requested services will be performed.*
☐	*Retro Request*	*Requests for services that have already been 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*

Required Information: To ensure our members receive quality care, appropriate claims payment and notification of servicing providers, please complete this form in its entirety. Please type or print in black ink and submit this request to the fax number above**.**

MEMBER INFORMATION		
Ohana ID :	**Last Name:**	**First Name, MI:**
Medicaid/Medicare # :	**Phone Number:**	**Date of Birth:**

REQUESTING PROVIDER INFORMATION		
Ohana ID Number:	**NPI Number/Tax ID:**	
Last Name:	**First Name:**	
Street Address:	**City, State:**	**Zip Code:**
Phone Number:	**Fax Number:**	
Provider Type/Specialty:	**Name of Requester:**	

TREATING PROVIDER INFORMATION		
☐ **Out of Network** If yes, please provide reason:		
Ohana ID Number:	**NPI Number:**	
Last Name:	**First Name:**	
Street Address:	**City, State:**	**Zip Code:**
Phone Number:	**Fax Number:**	
Provider Type/Specialty:	**Name of Requester:**	

FACILITY INFORMATION		
Ohana ID Number:	**NPI Number:**	
Facility Name:	**Phone Number:**	**Fax Number:**
Street Address:	**City, State:**	**Zip Code:**

SERVICE REQUESTED		
Planned Date of Service : / /		
Primary ICD-10 Code :	Description :	
CPT-4 Code(s)	**Description(s)**	**Visits / Frequency**
Please include additional procedures code and pertinent Clinical Summary below: (Attach supporting clinical records, if necessary).		

*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.*

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