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

# 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 14 days prior to the date the requested services will be performed. |
| ☐ Expedited Request<br>**(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.<br>**Physician Signature Validating Expedited Request** ______ Date Signed ______ |

☐ Precertification Request ☐ Payment Determination Request ☐ Out-of-State / Out-of-Network ☐ Off-Island Travel (Complete Page 2)

## 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 |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

PT/OT/Aqua/Speech Therapy: ☐ Initial Request ☐ Continuing--Last DOS: ______ Total Visits Used: ______

Pregnancy Notification (Global OB Authorization): ☐ High-Risk EDD: ______ 1st Prenatal Visit: ______

## 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 'Ohana 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.**

*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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## Off-Island Travel Request Information

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.**

| **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 | Departure Date: | Return Date: |
| Type of Ticket: ☐One-way ☐ Round-trip | 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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