TRANSPORTATION REQUEST

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

☐ On Island ☐ Off Island

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

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 _____

Provider Information

Requesting /Referring Provider Name _____ 'Ohana ID NPI Provider Address _____

Phone Number _____ Fax Number _____

Treating Provider Name _____ Wellcare ID NPI Provider Address _____

Phone Number _____ Fax Number _____

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 accommodations, 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 & birthdate 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:

*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 that 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) that should be treated within 24 hours.*

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