HMSA

Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA PRECERTIFICATION Request Form

Please fax completed form to: (808) 944-5611

Or Mail to: HMSA
Medical Management Department
P. O. Box 2001
Honolulu, Hawaii 96805-2001

Phone Nos: (808) 948-6464 Oahu
(800) 344-6122 Neighbor Island

☐ **Precertification Request*** ☐ **Payment Determination Request** ☐ **HMO Administrative Review**

(*For HMO members, check Administrative Review box if services are being performed by an In-State Nonparticipating or Out-Of State Provider)

PROVIDER CONTACT INFORMATION

Any questions or concerns regarding this request may be directed to:

Contact Name (First, Last) _____ Phone Number _____ Fax Number _____

A. MEMBER INFORMATION

Membership Number _____ Patient's Name (Last, First, MI) _____ Date of Birth _____

Subscriber's Name (Last, First, MI) _____ Phone number _____

B. ICD-9-CM DIAGNOSIS CODE(S)

Code(s): _____ _____ _____ _____

C. PROCEDURE/SERVICE/TREATMENT INFORMATION

CPT/HCPCS Code(s): _____ _____ _____ _____

Place of Service: ☐ Inpatient ☐ ASC (Ambulatory Surgical Center) ☐ Outpatient ☐ Office

D. PROVIDER INFORMATION

Requesting (or referring) Provider Name _____ Provider ID _____

Address _____

Phone Number _____ Fax Number _____

Servicing Provider Name (if different from requesting [or referring] provider) _____ Provider ID _____

Address _____

Phone Number _____ Fax Number _____

Servicing Facility/Vendor Name _____ Provider ID _____

Address _____

Phone Number _____ Fax Number _____

E. REASON FOR REFERRAL TO IN-STATE NONPARTICIPATING OR OUT-OF-STATE PROVIDER

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To avoid delays, please attach supporting documentation.