

## REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUEST FORM

Medical Management Prior Auth Line: (808) 973-1657

1357 Kapiolani Blvd, Suite 1250, Honolulu, HI 96814 Phone: 973-1650 (Oahu) or 1-800-434-1002 (NI) Fax: 973-0676 (Oahu) or 1-888-667-0680 (NI)

MEM	BER ID:		!	PCP NAME:				
NAME:				PHONE: FA		FAX:		
PHON	NE:	D.O.B.	1	CONTACT PER	RSON:			
				AUTHORIZE	D SIGNATURE:			
R E	PCP REFERRAL TO SPECIALTY CARE: Please select referral category by checking the appropriate box and complete the referral effective date range. If date range is not specified, referral will be effective for a period of one (1) year from request date.							
F E	DOCTOR:			SPECIALTY:				
R R A L	CONTACT PERSON:			PHONE: FAX:				
	ICD-9 CODE(S):			DIAGNOSIS:				
	☐Consult only ☐Consu	It & Treat 🔲 Con	ısult, Treat, &	& Follow-up	DOS To:	From:		
	REQUEST FOR TREATMENT THAT REQUIRES PRIOR AUTHORIZATION: Please complete the requested information below. Please attach clinical notes/documentation of medical necessity for requested service. * If requesting continuing PT/OT/ Speech/Aqua therapy, please send initial and/or updated evaluation and progress notes.							
P R I O R	FACILITY:			Outpatient Inpatient LOS:				
	FACILITY DEPT:			FAX:				
	ICD-9 CODE(S):			DIAGNOSIS:				
	CPT/HCPCS CODE:			REQUESTED SERVICE:				
_	CPT/HCPCS CODE:			REQUESTED SERVICE:				
A   U	*PT/OT/Aqua/Speech Therapy: Initial Request Continuing Last DOS: Total Visits Used:							
T	DATE OF SERVICE: From To OR Pending Authorization							
+				REASON FOR EXPEDITED REQUEST: YES NO				
0						VEC   NO		
O R		i:				QUEST: LYES LNO		
O R I Z A	REQUEST: AUTHORIZED SIGNATURE TRAVEL REQUEST: QUES that cannot be obtained on the	T benefit only. Tr		ther means (e.	DA  if required to provid g., family, public tra	TE: le medically necessary services insportation) is available.		
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