# REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUEST FORM

AlohaCare
*Aloha is the difference*

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)

| | | | |
|---|---|---|---|
| **MEMBER ID:** | | **PCP NAME:** | |
| **NAME:** | | **PHONE:** | **FAX:** |
| **PHONE:** | **D.O.B.** | **CONTACT PERSON:** | |
| | | **AUTHORIZED SIGNATURE:** | |

**REFERRAL**

**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.

| | | | |
|---|---|---|---|
| **DOCTOR:** | | **SPECIALTY:** | |
| **CONTACT PERSON:** | | **PHONE:** | **FAX:** |
| **ICD-9 CODE(S):** | | **DIAGNOSIS:** | |

☐ **Consult only** ☐ **Consult & Treat** ☐ **Consult, Treat, & Follow-up** **DOS To:** **From:**

**PRIOR AUTHORIZATION**

**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.

| | | | |
|---|---|---|---|
| **FACILITY:** | | ☐ **Outpatient** ☐ **Inpatient** | **LOS:** |
| **FACILITY DEPT:** | | **FAX:** | |
| **ICD-9 CODE(S):** | | **DIAGNOSIS:** | |
| **CPT/HCPCS CODE:** | | **REQUESTED SERVICE:** | |
| **CPT/HCPCS CODE:** | | **REQUESTED SERVICE:** | |

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

**DATE OF SERVICE: From** **To** **OR** ☐ **Pending Authorization**

**REASON FOR REQUEST:** **EXPEDITED REQUEST:** ☐ **YES** ☐ **NO**

**AUTHORIZED SIGNATURE:**_____ **DATE:**

**TRAVEL REQUEST: QUEST benefit only.** Travel benefits are considered if required to provide **medically necessary** services that cannot be obtained on the member's home island and/or **no** other means (e.g., family, public transportation) is available.

| | | | | |
|---|---|---|---|---|
| ☐ Air Transportation | DATE: | Apt. Time: | From: | To: |
| Auth #: PA | DATE: | Return Time: | From: | To: |
| ☐ Ground Transportation | DATE: | Apt. Time: | From: | To: |
| Auth #: PA | DATE: | Return Time: | From: | To: |
| ☐ Lodging | DATE: | Apt. Time: | From: | To: |
| Auth #: PA | DATE: | Return Time: | From: | To: |

**COMPANION REQUEST: (Medical Necessity Only)** ☐ **Yes** ☐ **No** **Name:** **Relation:**

**REASON FOR COMPANION REQUEST:**

**PREGNANCY NOTIFICATION:** Global OB authorization includes 3 OB ultrasounds. Prior auth required for additional OB ultrasounds.

| | | | | |
|---|---|---|---|---|
| **HIGH RISK** ☐ **Yes** ☐ **No** | **LMP:** | **EDC:** | **1st. Prenatal Visit:** | **Newborn PCP:** |

**FOR ALOHACARE USE ONLY:**

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ **ACA** | ☐ **ACAP** | ☐ **QUEST** | ☐ **QUEST-Net** | ☐ **QUEST-ACE** | **Auth #: PA** | **Pending Date:** |

| | | |
|---|---|---|
| ☐ **Approve** | **Date:** | **Reason:** |
| ☐ **Deny** | **Date:** | |

**AUTHORIZED SIGNATURE:**_____ **DATE:**

Referral Form Revised 12-2003; 11-2005 ;10-2007, 4-2008, 8-2008



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