

PRIOR AUTHORIZATION REQUEST FORM

Phone Number: (808) 522-4100 Fax Number: (808) 522-4174

PATIENT INFORMATION:

Medical Record Number (MRN): _____

Last Name: _____ First Name: _____ DOB: _____

INSURANCE INFORMATION:

HMSA Policy No.: _____ Primary Secondary

REQUESTING HHP PROVIDER INFORMATION:

HHP Requesting Provider Name: _____ Date Requested: _____

Completed by: _____ Phone Number: _____ Fax Number: _____

SERVICES REQUESTED

Requested Service: HMSA Advance Imaging HMSA Cardiology

Servicing Facility / Location: Kapi'olani Medical Center Pali Momi Medical Center Straub Medical Center Wilcox Medical Center

Other: _____

Service Facility Phone Number: _____ Servicing Facility Fax Number: _____

ICD-10 Code(s):	Diagnosis(s):	CPT Code(s):	Service Description(s):
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date of Service: _____ / _____ / _____

Comments: _____

If this is STAT, please select one of the reasons below to obtain immediate authorization. Please call our Prior Authorization Department at 808-522-4100 thereafter so we can prioritize the request in our work queue. Your Office may be contacted by NIA to provide clinical reasons that cases is clinically urgent:

- Cannot be postponed for 24 hours w/o risking progressing progression to an emergent condition.
- Cannot be postponed for 24 hours w/o risking loss of life / limb / risk of permanent disability.
- In the opinion of physician with knowledge of patient's medical condition, would subject patient to severe pain that cannot be adequately managed w/o care of treatment that is the subject of the case.
- Not Clinically Urgent / STAT.

Final determination from the insurance company will be completed by the Prior Authorization Department:

Approved Returned / Unable to Process Not Approved / Denied

Authorization No.: _____ Validation Dates: _____ to _____

Comments: _____

Completed by: _____ Date: _____