

# MANAGED CARE SERVICES

## REQUEST FOR "ESSENTIAL ADVANTAGE (HMO)" REFERRAL / HMSA MEDICARE PLAN

Managed Care Services • Phone: (808) 535-7260 • Fax (808) 535-7265

This authorization confirms a referral from HHP. This is NOT a guarantee of payment.

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ MR No.: \_\_\_\_\_

### INSURANCE

HMSA / Essential Advantage (HMO): Policy No.: \_\_\_\_\_  Primary  Secondary

Other Carrier: Plan/Policy No.: \_\_\_\_\_  Primary  Secondary

### REQUESTING EA PROVIDER INFORMATION

EA Requesting Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Completed by: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for Out-of-Network Referral:

No EA Provider Available  Member Request  Member Self-Referred

Out-of-Network  
Provider Request Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### SERVICES REQUESTED

Service Provider: \_\_\_\_\_ CPT Code(s) \_\_\_\_\_ Service Description \_\_\_\_\_

Facility/Location: \_\_\_\_\_

Place of Treatment:  Office  HOP  HIP  Home \_\_\_\_\_

Dates of Service(s): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

OR  Pending Authorization  DME  Rental  Purchase

ICD-10 Code(s)	Description	HCPCS	Description
_____	_____	_____	_____
_____	_____	_____	_____

Indication for Tx/Comments: \_\_\_\_\_

### The following MUST be completed by Hawai'i Health Partners Managed Care for authorization:

Approved  Not Approved/Unable to Process  Services available in network (EA)

Not Approved Service Dates \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

HMSA Referral No.: \_\_\_\_\_  Office Visits/Treatment No. of visits \_\_\_\_\_

Comments: \_\_\_\_\_  Consult  Second Opinion Only

\_\_\_\_\_  Rehab Therapy No. of visits \_\_\_\_\_

\_\_\_\_\_  Includes Evaluation  PT  OT  Speech

\_\_\_\_\_  Hospitalization  Surgery/Procedure  Lab/Imaging/Diagnostics

\_\_\_\_\_  Other: \_\_\_\_\_

Decision Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ By \_\_\_\_\_

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