HAWAIʻI PACIFIC HEALTH | HAWAIʻI HEALTH PARTNERS

CREATING A HEALTHIER HAWAIʻI

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 Hawaiʻi Health Partners Managed Care for authorization:

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

☐ Not Approved Service Dates ____ / ____ / ____ to ____ / ____ / ____

HMSA Referral No.: _____ ☐ Office Visits/Treatment No. of visits _____

_____ ☐ Consult ☐ Second Opinion Only

Comments: _____ ☐ Rehab Therapy No of visits _____

_____ ☐ Includes Evaluation ☐ PT ☐ OT ☐ Speech

_____ ☐ Hospitalization ☐ Surgery/Procedure ☐ Lab/Imaging/Diagnostics

_____ ☐ Other: _____

Decision Date ____ / ____ / ____ By _____