HMA
HAWAII - MAINLAND ADMINISTRATORS

Authorization Request

Please Fax All Requests to: **866-206-5655**

☐ **Non-Urgent** *(minimum 7 days notice)* ☐ **Urgent** *(minimum 2 days notice)* Today's Date: _____

ALL CLINICAL DOCUMENTATION MUST BE ATTACHED TO AVOID PROCESSING DELAYS
ALL CLINICAL NOTES AND/OR ORDERS ONLY ACCEPTED FROM MD, NP/FNP, PA-C or APRN

MEMBER INFORMATION (*Denotes required field)

*Patient Name: _____ *Date of Birth: _____ *Gender: Female ☐ Male ☐

*Member ID#: _____ *Primary Insurance: _____ Other Insurance: (TPL, Worker's Comp): _____

Address: _____ Phone Number: _____

Date & Place of Injury (if applicable): _____

PROVIDER INFORMATION (*Denotes required field)

***Referring Provider Name:** _____ *Phone: _____ Fax: _____
*NPI#: _____ *Tax ID#: _____

*Address: _____

***Servicing/Treating Facility/Provider:** ☐ *Same as Requesting* *Phone: _____ Fax: _____
*NPI#: _____ *Tax ID#: _____

*Address: _____

SERVICE TYPE REQUIRING AUTHORIZATION *(Check all that apply)*

Ambulatory/Outpatient Services/Office
- ☐ Surgery/Procedure
- ☐ Infusion or Oncology Drugs
- ☐ Chemo
- ☐ Dialysis
- ☐ Injections

Equipment/Supplies
- ☐ Renal Supplies
- ☐ CPAP
- ☐ Oxygen
- ☐ Prosthetic Device
- ☐ Purchase / Rental ☐

Purchase/Rental Price $

Home Services
- ☐ SN ☐ ST ☐ PT
- ☐ OT ☐ MSW ☐ HHA
- ☐ Hospice ☐ Respite Care
- ☐ Infusion Therapy

Inpatient Care/Observation
- ☐ Acute Medical/Surgical
- ☐ Long Term Acute Care
- ☐ Acute Rehab
- ☐ Skilled Nursing Facility
- ☐ Observation ☐ Transplant

Radiology/Laboratory
- ☐ Mammogram ☐ CT/CTA
- ☐ Pet Scan ☐ MRI/MRA
- ☐ Lab ☐ Ultrasound

Outpatient/Therapy
- ☐ SN ☐ ST ☐ PT
- ☐ OT ☐ Pulmonary/Cardiac Rehab

☐ **Other**-please specify:

Place of Service (choose one): ☐ Office ☐ Inpatient Hospital ☐ Outpatient Hospital ☐ Ambulatory Surgical Center ☐ Other

DIAGNOSIS/PLANNED PROCEDURE INFORMATION (*Denotes required field)

*Services Requested (Description & CPT/HCPCS/J-Code(s):

*Principal Diagnosis (Description & ICD-10 Code(s)):

Units/Type Requested: _____ (# of Units) _____ (Service Type (hours,days, visits, dosage))

*Service Start Date: _____ *Service End Date: _____

CONTACT PERSON/REVIEW REQUIRED DOCUMENTATION ATTACHED (*Denotes required field)

*Contact Person/Title: _____ *Phone: _____ Fax: _____
Email: _____ *Tax ID#: _____

Clinicals and Provider Order or Provider Signature required to accept authorization request for review.

*Are Clinicals Attached? ☐ Yes ☐ No
*Is Order Attached? ☐ Yes ☐ No

Provider Signature _____ **Date** _____

PLEASE NOTE: ***ALL ABOVE SECTIONS OF THIS FORM MUST BE COMPLETED IN FULL IN ORDER FOR REQUEST FOR AUTHORIZATION TO BE ACCEPTED FOR REVIEW. INCOMPLETE SUBMISSIONS WILL BE RETURNED.***

Authorization is based on the medical appropriateness of the services requested and should not be a guarantee of coverage or payment. Actual benefit payment is contingent upon eligibility, benefits available at the time service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, as well as other provisions of the medical plan.

Authorization Requests for Cigna Network please contact (800) 448-3585 in order to obtain an Authorization approval.
Authorization Requests utilizing all other networks - please complete form in its entirety and fax to (866) 293-9665.

Hawaii Mainland Administrators ∞ 1440 Kapiolani Blvd, Suite 1020, Honolulu, HI 96814 ∞ **Phone:** 808-951-4621 **Toll Free:** (866) 377-3977