Prior Authorization Form

Please Fax All Requests to: 866-293-9665
Please Attach Supporting Clinical Documentation

MEMBER INFORMATION		
Name:	**Date of Birth:**	**Gender:** ☐ **Female** ☐ **Male**
Member ID#:	**Primary Insurance:**	**Other Insurance (TPL, Workers' Comp):**
Address:		**Phone Number:**
Date & Place of Injury (if applicable):		

REFERRING/ORDERING PROVIDER INFORMATION		
Name:	**NPI#:**	**Tax ID#:**
Address:		
Name of Contact Person:	**Phone:**	**Fax:**

TREATING SPECIALIST/FACILITY INFORMATION		
Name:	**NPI#:**	**Tax ID#:**
Address:		
Name of Contact Person:	**Phone:**	**Fax:**

REQUESTED SERVICE(S)				
Service(s) Requested:				**# of Treatments/Items Requested:**
Diagnosis:	**ICD-10 Code(s):**			
CPT, HCPC or J-Code(s): **Please include units per code, purchase/rental price for DME, and dosage amounts for medications**				
Place of Service (choose one): ☐ **Office** ☐ **Inpatient Hospital** ☐ **Outpatient Hospital** ☐ **Ambulatory Surgical Center** ☐ **Other**				
Requested Date(s) of Service:	**Service(s) Rendered:** ☐ **Yes** ☐ **No** **Pending Authorization:** ☐ **Yes** ☐ **No**			

Prior authorization is based on the medical necessity of the services requested. 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.

PLEASE NOTE: ALL ABOVE SECTIONS OF THIS FORM MUST BE COMPLETED IN FULL IN ORDER FOR REQUEST FOR PRIOR AUTHORIZATION TO BE ACCEPTED FOR REVIEW.

ALL CLINICAL NOTES AND/OR ORDERS ONLY ACCEPTED FROM MD, NP, FNP, AND APRN.

Hawaii-Mainland Administrators 1600 West Broadway Road, Suite 300, Tempe, Arizona 85282 **Toll-Free:** (800) 448-3585