Pacific Administrators, Inc.
1440 Kapiolani Blvd, Suite 800 Honolulu, Hawaii 96814 Phone: (808) 441-8700 Fax: (808) 441-8751

PRIOR AUTHORIZATION REQUEST FORM

The Hawaii Laborers' Health & Welfare Fund

IMPORTANT: Eligibility and benefits inquiry should be completed first to confirm eligibility, verify coverage, and determine whether a prior authorization is required by the benefit plan by contacting Member Services Department at (808) 441-8700.

☐ **Urgent Authorization:** The definition of **Urgent** is any service for care where failure to provide the services could seriously endanger the patient's life. Please allow 72 hours from the receipt of your authorization request for a response.

☐ **Non-Emergent Authorization:** Please allow 10-15 business days from the date of receipt to process non-emergent authorizations.

COMPLETE ALL INFORMATION ON THE PRIOR AUTHORIZATION REQUEST FORM AND FAX TO 808-441-8751.

MEMBER INFORMATION	
Patient Name:	DOB:
Subscriber Name:	Member ID:

REQUESTING PROVIDER INFORMATION		
Requesting Provider Name:	Contact Person:	Tax ID:
Telephone:	Fax:	Address:

RENDERING PROVIDER/FACILITY INFORMATION (IF DIFFERENT FROM REQUESTING PROVIDER)		
Provider/Facility Name:	Contact Person:	Tax ID:
Telephone:	Fax:	Address:

SERVICE TYPE REQUIRING AUTHORIZATION (CHECK ALL THAT APPLY)

Ambulatory /Outpatient services: □ Surgery/ Procedure □ IV Infusion or Oncology Drugs □ Chemo/ Rad Tx □ Injections	**Durable Medical Equipment (DME):** □ Purchase □ Rental □ BI/CPAP/Supplies □ Orthotics □ Hearing Aids □ Other	**Home Health / Hospice:** □ Home Health : ○ SN ○ PT ○ OT ○ ST □ Hospice □ Home Infusion Therapy	**Inpatient Care:** □ Acute Medical/Surgical □ Acute Rehab □ SNF
Nutrition / Counseling: □ Medical Nutrition □ Diabetic Counseling/Training	**Outpatient Therapy:** □ Occupational Therapy □ Physical Therapy □ Speech Therapy	**Imaging:** □ MRI □ PET/CT Scan □ Cardiac CT	**Transportation:** □ Non- emergent inter island (ground and air) □ Mainland □ Flight Companion
Ancillary: □ Dental Procedure □ Sleep Studies (includes HST) □ IVF □ Genetic Studies/Tests □ Substance Abuse (Residential)		**OTHER: Please Specify**:	

DIAGNOSIS/ CPT CODES	
Diagnosis Description/ ICD10 Code(s):	CPT/ HCPCS Code(s)/ include units as applicable:
Diagnosis Description/ ICD10 Code(s):	CPT/ HCPCS Code(s)/ include units as applicable:
Diagnosis Description/ ICD10 Code(s):	CPT/ HCPCS Code(s)/ include units as applicable:
Service Start Date:	Service End Date:

Required documentation: To avoid any delays in this process, please provide supporting documentation along with this Request Form including but not limited to medical history, diagnostic reports, and progress notes.

Outpatient therapy services: Please include a copy of the Initial &/or Re-evaluation treatment plan (signed by the requesting physician) with this request form.