



1440 Kapiolani Blvd, Suite 800 Honolulu, Hawaii 96814 Phone: (808) 441-8711 Fax: (808) 441-8751

**PRIOR AUTHORIZATION REQUEST FORM**

**The Hawaii Laborers' Health & Welfare Trust Fund Office**

**Important:** Eligibility and benefits inquiry should be completed first to confirm eligibility, verify coverage, and determine whether or not a prior authorization is required by the benefit plan.

COMPLETE ALL INFORMATION ON THE PRIOR AUTHORIZATION REQUEST FORM.

<b>Health Plan Fax: (808) 441- 8751</b>		<b>Date Form Completed and Faxed:</b>	
<b>SERVICE TYPE REQUIRING AUTHORIZATION (Check All That Apply)</b>			
<b>Ambulatory / Outpatient services:</b> <input type="checkbox"/> Surgery/ Procedure <input type="checkbox"/> IV Infusion or Oncology Drugs <input type="checkbox"/> Chemo/ Rad Tx <input type="checkbox"/> Injections	<b>Durable Medical Equipment (DME):</b> <input type="checkbox"/> Purchase <input type="checkbox"/> Rental <input type="checkbox"/> BI/CPAP/Supplies <input type="checkbox"/> Orthotics <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Other	<b>Home Health / Hospice:</b> <input type="checkbox"/> Home Health (Please circle one: <b>SN PT OT ST</b> <input type="checkbox"/> Hospice <input type="checkbox"/> Home Infusion Therapy	<b>Inpatient Care:</b> <input type="checkbox"/> Acute Medical/ Surgical <input type="checkbox"/> Acute Rehab <input type="checkbox"/> SNF
<b>Nutrition / Counseling:</b> <input type="checkbox"/> Medical Nutrition <input type="checkbox"/> Diabetic Counseling/ Training	<b>Outpatient Therapy:</b> <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy	<b>Imaging:</b> <input type="checkbox"/> MRI <input type="checkbox"/> PET/CT Scan <input type="checkbox"/> Cardiac CT	<b>Transportation:</b> <input type="checkbox"/> Non-emergent (inter island; ground and air) <input type="checkbox"/> Mainland
<b>Ancillary:</b> <input type="checkbox"/> Dental Procedure <input type="checkbox"/> IVF <input type="checkbox"/> Sleep Studies (includes HST) <input type="checkbox"/> Genetic Studies/Tests <input type="checkbox"/> Substance Abuse (Residential)		<b>OTHER- Please Specify:</b>	
<b>PROVIDER INFORMATION (*Required Field)</b>			
*Requesting Provider Name:		*Address:	
		*Telephone:	
		*Fax:	
*Servicing Provider/ Facility Name: <input type="checkbox"/> Same as requesting Provider		Address:	
*Servicing Provider Tax ID:			
*Contact Person:		*Phone:	Fax:
<b>MEMBER INFORMATION (*Required Field)</b>			
*Patient Name:		* <input type="checkbox"/> Male <input type="checkbox"/> Female	*DOB:
*Health Insurance ID:		Subscriber Name:	
<b>DIAGNOSIS/ CPT CODES (*Required Field)</b>			
*Diagnosis Description/ ICD10 Code(s):		*CPT/ HCPCS Code(s)/ include units as applicable:	
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*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 from 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.