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.

Health Plan Fax: (808) 441- 8751	**Date Form Completed and Faxed:**

SERVICE TYPE REQUIRING AUTHORIZATION (Check All That Apply)

Ambulatory / Outpatient services:	**Durable Medical Equipment (DME):**	**Home Health / Hospice:**	**Inpatient Care:**
□ Surgery/ Procedure □ IV Infusion or Oncology Drugs □ Chemo/ Rad Tx □ Injections	□ Purchase □ Rental □ BI/CPAP/Supplies □ Orthotics □ Hearing Aids □ Other	□ Home Health (Please check one: **SN PT OT ST** □ Hospice □ Home Infusion Therapy	□ 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
Ancillary: □ Dental Procedure □ IVF □ Sleep Studies (includes HST) □ Genetic Studies/Tests □ Substance Abuse (Residential)		**OTHER- Please Specify**:	

PROVIDER INFORMATION (*Required Field)

*Requesting Provider Name:	*Address: *Telephone: *Fax:
*Servicing Provider/ Facility Name: □ Same as requesting Provider *Servicing Provider Tax ID:	Address:
*Contact Person:	*Phone: Fax:

MEMBER INFORMATION (*Required Field)

*Patient Name:	*□ Male □ Female	*DOB:
*Health Insurance ID:	Subscriber Name:	

DIAGNOSIS/ CPT CODES (*Required Field)

*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 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.