PRINT FORM CLEAR FORM

1440 Kapiolani Blvd, Suite #1020, Honolulu, Hawaii 96814
HMA: Phone: (808) 951-4621 or Toll free: (866) 377-3977

****Please fax all requests to: 866-206-5655****

PRIOR AUTHORIZATION FORM

Referring Provider or Primary Care Physician:		
Address of Referring Provider or Primary Care Physician:		
Name of Office Contact Person:	**Phone:**	**Fax:**
PATIENT INFORMATION		
Patient Name:	**Date of Birth:**	**Sex:** ☐ **F** ☐ **M**
Patient ID #:	**Primary Insurance:**	
Patient's Phone:		
Address:		
Other Insurance (Third Party Liability, Workmen's Compensation):		
Date of Injury:		
TREATING SPECIALIST OR TREATING FACILITY INFORMATION		
Name of Treating Specialist or Facility:		
Address of Treating Specialist or Facility:		
Name of Office Contact Person:	**Phone:**	**Fax:**
Service(s) Requested:	**# of Units or Treatments Requested:**	**Requested Dates of Service:**
Diagnosis (Required):		☐ **Inpatient** ☐ **Outpatient**
Required: ICD 9:	**CPT Code:**	**HCPC Code:**

Prior authorization is based on the medical necessity of the services requested. Actual benefit payment is contingent on eligibility and the provisions of the medical plan. The subscriber or their dependents, together with his or her physician is ultimately responsible for determining the appropriate course of medical treatment, regardless of what the plan will pay