Hawaii authorization request for air transportation, lodging and meals

Urgent:	Yes	Today's date :		Fax to 800-267-8328

Member information

Name (Last, First, Middle):		Member Plan ID#:
Gender:	Home street address: (Do not enter P.O. box):	
ZIP:	Phone:	Alternate phone:
Date of birth:	Contact person (Relationship):	Phone:

PCP information

PCP name:	Contact name:
Phone:	Fax:

Referring medical provider information

Name (Last, First, Middle):		Specialty:
Contact name:	Phone:	Fax:

Appointment information

Treatment/description of medical service:	Consult	Follow-up	Other:

Medical reason for treatment (including diagnosis):

Reason for request (i.e., no specialist on island of residence, procedure cannot be done on island or residence, etc.)

Rendering physician:		Phone:
Specialty:	Start date mm/dd/yy:	Check-in time:

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Appointment information (cont.)

End date mm/dd/yy:

End time:

Physical street address:

Island or state:

Facility:

Additional appointment:

Rendering physician:

Phone:

Specialty:

Start date dd/mm/yy:

Check-in time:

End date dd/mm/yy:

End time:

Physical street address:

Island or state:

Facility:

Travel request information:
Please attach clinical information to support any request to travel out of state.

Departure city/airport:

Arrival city/airport:

Departure date dd/mm/yy:

Return date dd/mm/yy:

Medical reason for stay longer than 1 day:

Type of ticket: One-way   Round-trip

Attendant required: Yes   No

Medical reason for attendant:

Name of adult attendant (as listed on valid photo ID):

Gender:

Date of birth:

Ground transportation required:
Home island   Neighbor island   Mainland   Not required

Do not use this field to indicate a need for airport W/C assistance Member provides W/C?   Yes   No
What type?
Able to transfer in/out of W/C?   Yes   No

Meals Required: Yes   No

Lodging Required: Yes   No

Oxygen Required: Yes   No   If Yes: Nasal   Mask   O2   Flow Rate:

Comments

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