



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)			
<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 : <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 <input type="checkbox"/> Flight Companion
<b>Ancillary:</b> <input type="checkbox"/> Dental Procedure <input type="checkbox"/> Sleep Studies (includes HST) <input type="checkbox"/> IVF <input type="checkbox"/> Genetic Studies/Tests <input type="checkbox"/> Substance Abuse (Residential)		<b>OTHER: Please Specify:</b>	
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.