PRIOR AUTHORIZATION REQUEST FORM (Rev. 10/2018)

Phone: 532-6989 (O'ahu)/1-800-851-7110 (Neighbor Islands)
FAX TO: 532-6999 (O'ahu)/1-800-688-4040 (Neighbor Islands)
For additional copies of this form, go to www.mdxhawaii.com.

Today's Date: _____ **PLEASE PRINT LEGIBLY.**

SECTION 1: REQUESTING PROVIDER

Provider's Name:_____ **Specialty:**_____

Address/Location *(required)*:_____

Contact Name:_____ **Phone #**:_____ **Fax #**:_____

Note: If this is an HMO member, you must be approved to see this member before requesting services.

❒ **Check "✓" this box if you would like to request a peer-to-peer conversation with an MDX Hawai'i Physician Reviewer before a determination is made.** *We will contact you to arrange a date and time for your dialogue with our Medical Reviewer. Or, call us at* ***(808) 426-7617*** *to schedule and provide best contact date(s)/time(s) and phone number of the Provider.*

❒ Routine ❒ Urgent MD signature ⌦_____*(Urgent requests require **MD** signature)*

SECTION 2: PATIENT

Check one: ❒ UnitedHealthcare ❒ Humana

Patient Name: _____ **Date of Birth**:_____

Member ID #: _____ **Sex:** ❒ Male ❒ Female

Home Address: _____ **Best Contact Phone** # *(required)*:

City, State & Zipcode: _____

SECTION 3: REFERRED TO PROVIDER

Provider's Name: _____ **Specialty:**_____

Address/Location *(required)*:_____

Contact Name:_____ **Phone #**:_____ **Fax #**:_____

SECTION 4: SERVICE LOCATION

Service Location: ❒ Home ❒ Office ❒ Outpatient Hospital ❒ Ambulatory Surgery ❒ Inpatient-ELOS:_____

Facility Name:_____

Address:_____

Office Contact Name:_____ **Phone #:**_____ **Fax #:**_____

SECTION 5: MEDICAL/TREATMENT

Date of Service (DOS): **From:**_____ **To:**_____ ❒ *DOS Pending Authorization*

Please attach clinical notes/documentation of medical necessity for requested services.	
ICD-10 Diagnosis Code(s)	**Diagnoses**
Procedure Code(s)	**Procedures / Treatments**
Durable Medical Equipment (DME): ❒ **Rental** ❒ **Purchase** (Attach MD order, medical documents, NCD and cost)	
PT/OT/ST: All requests for PT/OT/ST must include signed orders from the requesting provider. Ongoing services may not be submitted as "urgent".	
❒ **Initial Request**	❒ **Continuing:** Number of visits & frequency: _____ *How many visits did the patient already have?* _____Last DOS: _____ For PT/OT/ST, include the evaluation and progress notes.

Once approved by MDX Hawai'i's Medical Management Department, this authorization is valid for the listed number of authorized visit(s)/date(s), the condition as indicated, and only for the patient identified. NOTE: Coverage is dependent on member's eligibility and plan evidence of coverage at the time of service. All services are subject to medical necessity review.

PRIOR AUTHORIZATION REQUEST FORM (Rev. 10/2018)

Phone: 532-6989 (O'ahu)/1-800-851-7110 (Neighbor Islands)
FAX TO: 532-6999 (O'ahu)/1-800-688-4040 (Neighbor Islands)
For additional copies of this form, go to www.mdxhawaii.com.

SECTION 6: DRUGS AND MEDICATION

This section is for Medicare Part B medications that require prior approval when delivered in the physician's office, clinic, outpatient or home setting through home health or infusion companies. For the most current listing of medications that require prior authorization, please refer to the PA Look-Up Tool, Medications Tab on our website at www.mdxhawaii.com.

Patient Name: _____ **Prescriber Name**: _____

Attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

J-CODE and NDC	Drug Name	Dose	Directions for use/SIG
J-Code NDC			
J-Code NDC			
J-Code NDC			
J-Code NDC			
J-Code NDC			

Is the medication being requested for use in an ongoing investigational trial?
❒ NO ❒ YES If yes, Trial name: _____ Registration number _____

Is the request for a reauthorization?
❒ NO ❒ YES **If yes, how many treatments have been completed?** _____

Is the patient currently stable on therapy?
❒ YES ❒ NO

Provide the start date and **expected length of treatment.**

List all therapeutic alternatives previously used with start/end dates and outcomes:

Additional comments that would be of benefit to the review of this request:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that

MDX Hawai'i or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

☒ _____ _____

Prescriber Signature ***Date***

AN AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.
COVERAGE IS DEPENDENT ON THE MEMBER'S ELIGIBILITY AND PLAN EVIDENCE OF COVERAGE AT THE TIME OF SERVICE.
All services are subject to medical necessity review.