SPECIALTY REFERRAL 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.

PRIOR APPROVAL IS REQUIRED FOR REFERRALS TO A SPECIALIST OR FOR SPECIALTY CARE. FOR HUMANA HMO MEMBERS ONLY.

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

SECTION 1: REQUESTING PROVIDER

REQUESTING PROVIDER:

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

Address/Location:_____

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

SECTION 2: PATIENT

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

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

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

City, State & Zipcode: _____

SECTION 3: REFERRED TO PROVIDER

REFERRED TO PROVIDER: *Must be an MDX Hawai'i participating provider. If not, provide explanation for out-of-network referral.*

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

Address/Location *(required)***:** _____

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

Is this provider an MDX Hawai'i participating provider? ☐ Yes ☐ No; please provide explanation below:

Reason for out-of-network referral:_____

_____

SECTION 4: MEDICAL/TREATMENT

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

❒ **Evaluation and Treatment (99201 – 99215)** ❒ **Evaluation Only (99201 – 99205)**

Referral reason/remarks/limitations:_____

_____

Please attach clinical notes or documentation of medical necessity.

ICD-10 Diagnosis Code(s)	Diagnoses

Do not add procedure codes. If you are requesting services, use the PRIOR AUTHORIZATON REQUEST FORM (REV. 10/2018).

❒ **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.*

Signature of Requesting Physician: **Date:**

☒ _____ _____

THIS REFERRAL DOES NOT GUARANTEE PAYMENT OF NON-COVERED SERVICES.
COVERAGE IS DEPENDENT ON THE HMO MEMBER'S ELIGIBILITY AND PLAN BENEFIT AT THE TIME OF SERVICE.
ALL SERVICES ARE SUBJECT TO MEDICAL NECESSITY REVIEW.