949 Kamokila Boulevard, 3rd floor, Suite 350
Kapolei, HI 96707

OUTPATIENT AUTHORIZATION REQUEST AND PHYSICIAN REQUEST FOR TRANSPORTATION, LODGING, AND MEALS

Please Fax completed form to: **1-888-881-8225**
Customer Service Phone Numbers: **Medicare** 1-888-505-1201 **Medicaid** 1-888-846-4262

☐ Standard Request	Requests for prior authorization (with supporting clinical information and documentation) should be sent to Wellcare By 'Ohana 14 days prior to the date the requested services will be performed.
☐ Expedited Request **(MD Signature Required)**	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function. **Physician Signature Validating Expedited Request** — Date Signed

☐ Precertification Request ☐ Payment Determination Request ☐ Out-of-State / Out-of-Network ☐ Off-Island Travel (Complete Page 2)

Contact Information

List contact for any questions or concerns regarding this request:

Contact Name (Last, First) | Contact Phone Number | Contact Fax Number

Member Information

Wellcare ID Number | Member Name (Last, First , MI) | Date of Birth

Member Address | Member Phone Number

Service / Procedure / Treatment Information

Planned Date of Service: _____ to _____

ICD Dx Codes: _____ _____ _____ _____ _____ _____ _____

Place of Service: ☐ ASC Ambulatory Surgery Center ☐ Outpatient ☐ Office ☐ Home ☐ Other _____

CPT/HCPCS Code(s):

Code	# visits / units	Code	# visits / units	Code	# visits / units	Code	# visits / units
Code	# visits / units	Code	# visits / units	Code	# visits / units	Code	# visits / units

PT/OT/Aqua/Speech Therapy: ☐ Initial Request ☐ Continuing--Last DOS: _____ Total Visits Used: _____

Pregnancy Notification (Global OB Authorization): ☐ High-Risk EDD: _____ 1st Prenatal Visit: _____

Provider Information

Requesting /Referring Provider Name | Provider ID | Provider Type

Provider Address (Including City/State/ZIP Code)

Phone Number | Fax Number

Treating Provider Name | Provider ID | Specialty

Provider Address (Including City/State/ZIP Code)

Phone Number | Fax Number

☐ Check this box to skip this section and have 'Ohana assign the Facility

Facility Provider Name | Facility ID | Facility Type

Facility Address (Including City/State/ZIP Code)

Phone Number | Fax Number

Additional Information: i.e., Clinical Summary, Description of Request, Reason for referral to an Out-of-State/Out-of-Network Provider

Please attach supporting documentation to avoid delays.

*Authorizations will be given for medically necessary services only: it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergencies do not require prior authorization (An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result, without immediate medical attention, in serious jeopardy to the health of an individual). *Urgent Care is defined as medically necessary treatment for an injury, illness, or other type of condition (usually not life-threatening) which should be treated within 24 hours.*

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Member Name: Wellcare ID #:

Off-Island Travel Request Information

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Criteria:

- **Member must have Medicaid or CCS with Wellcare**
- **Appointments should be made for Monday through Thursday and no later than 2 p.m.**

Appointment Details Related to Travel		
Treating Provider Address (if different from above):		
Date member must be present:	Start Time:	Additional Info:
Date of expected release:	End Time:	Additional Info:

Travel Details		
Type of Request: ☐ Air ☐ Ferry	Departure Date:	Return Date:
Type of Ticket: ☐ One-way ☐ Round-trip	Departure City/Airport:	Arrival City/Airport:
To assure travel accomodations, please indicate Member's:	Height:	Weight:
Medical reason if stay is longer than one day:		
Lodging Required? ☐ No ☐ Yes	Meals required? ☐ No ☐ Yes	

Attendant Information	
Attendant Required? ☐ No ☐ Yes* **If yes, will require additional 24 hours to process*	Name & Birth date of adult attendant: *(As Listed on Valid Photo ID)*
Medical Reason for Attendant:	

Ground Transportation	
Ground Transportation Required? ☐ No ☐ Yes	Preferred Transportation Provider:
Needed on Home Island? ☐ No ☐ Yes	Needed at Treating Destination? ☐ No ☐ Yes

Medical Needs		
Wheelchair Required? ☐ No ☐ Yes	Has own Wheelchair? ☐ No ☐ Yes	If yes, type:
Oxygen required? ☐ No ☐ Yes	If yes: ☐ Nasal ☐ Mask	O2 flow rate:
Other special travel needs:		

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