UHA
HEALTH INSURANCE
Better **Health.** Better **Life.**

Participating Provider Handbook

CNS-0210-052020

Important Information About This Handbook

Information and sample forms provided in this handbook are subject to change at any time. For the most current updates that may not be included in this version of the Provider Handbook please visit us online at uhahealth.com/providernotice.

For the most up-to-date version of downloadable forms please visit us online at uhahealth.com Or call UHA Customer Services at 808-532-4000, or 1-800-458-4600 from the neighbor islands

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ABOUT UHA HEALTH INSURANCE

In 1996, a group of physicians put into action their belief that quality health care required physician leadership and a steadfast commitment to the ethical values of the medical profession by establishing UHA. UHA has emerged as a leader in health care quality and is recognized for quality customer service. UHA understands that the cornerstone of good health is wellness and prevention. We focus on helping members better their lives by providing benefits to promote health and prevent illness, and encourage members to take advantage of these benefits.

Our Mission

We strive to keep health insurance affordable by improving the health of our members. When benefits are needed, we ensure effective, timely, and compassionate delivery of health care.

Our Vision

Our vision is a vibrant, healthy Hawaii, where people require less medical intervention.

Our Values

Our Pledge to Our Members
Our associates serve to maximize their health and the health of our members, and to provide prompt help to our members and our valued partners who serve them.

Our Pledge for High Value Care
We provide access to high value care; best quality and cost to our members.

We ensure that health care policies are developed by physician leaders, committed to the ethical values of the medical profession.

We ensure that our members receive the safest, most effective, and compassionate care possible, while respecting the trusted relationship between a patient and physician.

We conduct ourselves at all times ethically, honestly, and with integrity. When making benefit decisions, we uphold ethical values of the medical profession and enable physician experts in the process. Members are encouraged to appeal decisions when they disagree and we ensure that the appeals process is impartial.

Our Pledge to Our People
We create a work environment where associates are healthy, happy, and productive.

Our Pledge to Innovate
We drive change while understanding its value in better serving our members through innovative products and services.

How to Contact UHA

UHA's experienced staff is available on weekdays between the hours of 8:00 a.m. and 4:00 p.m. to assist you. Please use the guide below to contact the correct department.

	UHA 700 Bishop Street, Suite 300 Honolulu, Hawaii 96813-4100 532.4000 on Oahu 1.800.458.4600 on neighbor islands		
For access to downloadable forms, the UHA Preferred Drug List, Prior Authorization List, an updated Provider Directory, Frequently Asked Questions, and Patient Eligibility Inquiries documents, please visit our website at: uhahealth.com			
For Assistance With	**Department to Contact**	**Telephone**	**Toll-Free Fax**
Patient eligibility, benefits, and pharmacy questions	Customer Services	Oahu: 532.4000 Neighbor islands: 1.800.458.4600, extension 352	866.572.4393
Prior authorizations for elective surgeries, hospital inpatient admissions and procedures, as well as out-of-state care	Health Care Services	Oahu: 532.4006 Neighbor islands: 1.800.458.4600, extension 300	866.572.4384
Claim status, initiating provider appeals	Customer Services	Oahu: 532.4000 Neighbor islands: 1.800.458.4600, extension 351	866.572.4393
Provider Agreements, amendments to the Provider Agreement, demographic changes, eligible charges and updated Provider Handbook	Customer Services	Oahu: 522.2268 Neighbor islands: 1.800.458.4600, extension 302	866.572.4383

How to Contact Express Scripts

Express Scripts can answer your questions quickly and accurately around the clock for questions about drugs managed under the member's pharmacy benefit manager (PBM). For medications managed under the member's medical benefit manager (MBM), any calls received outside of business hours will be returned the next business day.

Express Scripts Contact Information				
MBM/PBM	**Purpose**	**Phone**	**Fax**	**Hours**
PBM	**Member Customer Service:** Specific number for member inquiries; listed on the back of the member ID cards.	(855) 891-7978	N/A	Available 24/7
	Prior Authorizations: Contact for physicians to call or fax in PHARMACY prior authorizations.	(800) 753-2851	(877) 329-3760	
	Pharmacy Help Desk: For pharmacy use only to assist with getting a claim to adjudicate or understanding a reject message.	(800) 922-1557	N/A	
MBM	**Prior Authorizations:** Contact for physicians to call or fax in MEDICAL drug prior authorizations.	(866) 877-7042	(866) 877-7179 or visit online at: *express-path.com/Login.aspx*	Mon-Fri 8 a.m.--5 p.m. (EST) 2 a.m.=1 p.m. (HST)

Definitions

As used in the Agreement, each of the following terms (and the plural thereof, when appropriate) shall have the meaning set forth herein, except where the context makes it clear that such meaning is not intended. Capitalized terms are used within this section to indicate the term is defined.

"Clean Claim" means a properly completed billing form UB-04, CMS-1500, or such successor forms, as applicable, with complete CPT-4, HCPCS, ICD-9 or ICD-10 coding, submitted in accordance with the directions set forth in this handbook.

"Coordination of Benefits" means those provisions by which a Provider or UHA, either together or separately, seek to recover costs of Covered Services provided on behalf of an Eligible Person, which may be covered by another health care plan, service plan, government plan or insurance arrangement, subject to any conditions imposed by such coverage regarding such recovery.

"Copayment" means the amount that the Eligible Person is required to pay for Covered Services as set forth in the UHA Plan document.

"Covered Service" means any health care service or supply delivered to an Eligible Person by Provider which is: (a) pursuant to a Benefit (as that term is defined in a UHA Plan) covered by the terms of a UHA Plan; (b) Medically Necessary as defined in the Hawaii Revised Statutes, Section 432E-1.4; (c) delivered

after Prior Authorization has been obtained, when Prior Authorization is required; and (d) ordered by Eligible Person's Physician or other licensed health care Provider. If applicable, care which is only the result of a clear error in treatment or judgment on the part of a Provider shall not be considered a Covered Service.

"Deductible" means the fixed dollar amount that is payable by the Eligible Person each calendar year before benefits are payable by UHA.

"Eligible Charge" means the lower of Provider's billed charge or the agreed upon amount for reimbursement that Provider shall receive for Covered Services to Eligible Persons. UHA's actual payment to Provider shall be less the Eligible Person's Copayment.

"Eligible Person" means a person who is eligible to receive benefits under the terms of a UHA Plan as defined in Section 1.6 of your Participating Provider Agreement.

"Emergency Services" as defined in the Hawaii Revised Statute (section 432E-1)
"Emergency services" means services provided to an enrollee when the enrollee has symptoms of sufficient severity that a layperson could reasonably expect, in the absence of medical treatment, to result in placing the enrollee's health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death.

"Medical Director" means a Physician who is retained by UHA to coordinate and supervise prospective, concurrent, and retrospective review of Covered Services delivered to Eligible Persons. Where the approval or authorization of UHA is required by this Agreement, the UHA Medical Director may perform that task or delegate it to another qualified person, group, or entity.

"Medically Necessary" or "Medical Necessity" as defined in the Hawaii Revised Statute (section 432E-1.4):

"(a) For contractual purposes, a health intervention shall be covered if it is an otherwise covered category of service, not specifically excluded, recommended by the treating licensed health care provider, and determined by the health plan's medical director to be medically necessary as defined herein. A health intervention may be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity as defined by subsection (b) [below]. A managed care plan may choose to cover health interventions that do not meet the definition of medical necessity.

(b) A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is:

(1) For the purpose of treating a medical condition;
(2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient;
(3) Known to be effective in improving health outcomes; provided that:
    (A) Effectiveness is determined first by scientific evidence;
    (B) If no scientific evidence exists, then by professional standards of care; and
    (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and
(4) Cost-effective for the medical condition being treated compared to alternative health

interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price."

In general, "experimental" or "investigative" services will not be considered standard medical practice and, therefore, would not be Covered Services even though the Physician/Provider and the Eligible Person may decide to utilize such treatments. Please refer to the UHA payment policy for experimental and investigative services. uhahealth.com/forms#providers- Medical Payment Policies

"Participating" denotes, when used herein to modify another term, as in "participating physician," "participating provider," "participating hospital," and the like, that the Provider of services is under contract with UHA, which requires that such Provider collect only: (a) the Eligible Charge (UHA's payment plus any applicable Copayment); and (b) the applicable taxes.

"Physician" means a person with an M.D. or D.O. license to practice medicine in the State of Hawaii.

"Provider" a provider of health care services or supplies who is appropriately licensed or certified by the proper governmental authority to practice or provide such services, or dispense such supplies, and who renders services or dispenses supplies within the lawful scope of such license or certification.

"Scientific Evidence" as defined in the Hawaii Revised Statute (section 432E-1.4)
"Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and the health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. Scientific evidence may be found in the following and similar sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
(2) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National [Institutes] of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);
(3) Medical journals recognized by the Secretary of Health and Human Services under section 1861 (t)(2) of the Social Security Act, as amended;
(4) Standard reference compendia including the American Hospital Formulary Service-Drug Information, American Medical Association Drug Evaluation, American Dental Association Accepted Dental Therapeutics, and United States Pharmacopoeia-Drug Information;
(5) Findings, studies, or research conducted by or under the auspices of federal agencies and nationally recognized federal research institutes including but not limited to the Federal Agency for Health Care Policy and Research, National Institutes [of] Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services , Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services, and
(6) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

"UHA Plan(s)" means a plan of health care coverage for which UHA is the insurer or for which UHA provides claims processing or administrative services..

UHA Medical Plans

UHA provides comprehensive preferred provider medical plans to fit the needs of employer groups in Hawaii. You can obtain the UHA plan documents and a complete list of benefit information for a specific plan, see the Medical Benefits Guides posted on our website at uhahealth.com/forms#providers **- Benefit Plans**

Questions on plan benefits may be directed to UHA Customer Services at 532-4000, or 1-800-458-4600 from the neighbor islands. Employers may also select a variety of coverage options for prescription drug, vision, and dental benefits.

Vision and Hearing Appliances
UHA will reimburse Ophthalmologists, Optometrists, Audiologists or any other provider licensed to dispense the above referenced appliances according to the member's benefit. The member is responsible for paying the provider the difference between UHA's payment and the total actual charge for vision and hearing appliances only.

Listed below is an example of how to submit your claim for hearing aid appliances. If you are submitting claim(s) for both left and right ears, you must list them on 1 line as shown below:

Service Code	Mod	Units
V5255	LTRT	2

Prescription Drug Benefits

Understanding how UHA's prescription drug benefit programs work will assist you in making cost-effective choices when prescribing medication for your patients.

Members With a UHA Drug Plan
(Medical Plans only cover contraceptives, diabetic medications, insulin, supplies and oral chemotherapy medications for members who do not have a drug plan that covers these items).

Please contact UHA's Customer Services department at 532-4000 for the most up to date information regarding co-payments for our current drug plan.

Preferred brands are those drugs listed in UHA's Preferred Drug List (PDL). A copy of the Preferred Drug List is available online at uhahealth.com/forms#providers, or from our Customer Services Representatives. Keep in mind, this list is subject to change at any time and inclusion on the PDL does not guarantee the drug will be covered in all circumstances – in some cases drugs are not appropriate for specific diagnoses and are subject to medical review.

Reducing Your Patient's Out-Of-Pocket Expense For Drugs

You can help your patients reduce their out-of-pocket expense for prescription drugs by:

1. Prescribing generic drugs whenever possible.

2. When brand name drugs are appropriate, prescribe a preferred drug listed in UHA's Preferred Drug List.
3. Encouraging your patients on maintenance medications to take advantage of the Express Scripts Home Delivery or Extended Fill Program.

Members may also utilize the Extended Fill Program from most UHA-participating pharmacies within the Express Scripts network. This allows them to purchase the same supply as mail order (90 days for generic and 60 days for brand) for maintenance medications. The benefit for controlled substances is limited to a 30-day supply and other limitations such as quantity limits may apply.

Out-Of-State Services

When patients are traveling outside of Hawaii on business or vacation, UHA will cover **medically necessary** services received if they are **required unexpectedly on an emergency basis** and not related to the reason for travel.

However, when patients are referred out-of-state for medical services that may or may not be available in Hawaii, two weeks' advance notice is required for prior authorization to verify that the requested services meet UHA payment standards and are medically necessary, and to make payment arrangements with the out-of-state provider or facility.

To notify UHA of a potential mainland referral, please call UHA Health Care Services at 532-4006, or toll free from the neighbor islands at 1-800-458-4600, extension 300, and let the Health Care Services Representative know you are considering a referral to a mainland provider. You will be connected to a care manager who will make sure the patient is aware of the implications of receiving care outside of Hawaii. If you would like to discuss the necessity of the referral directly with a care management nurse, please call the number above.

Although we contract with First Health facilities, some of them are not participating with UHA, especially labs and anesthesiology groups. Please see the list of First Health facilities and other mainland providers who are not participating with UHA at uhahealth.com.

Unauthorized services may result in a contentious situation and significant out-of-pocket expenses for the member. We would like to avoid both and are hopeful you will help us do so.

SERVICES AVAILABLE TO UHA PROVIDERS

Online Provider Services

The **ONLINE PROVIDER SERVICES** is a web service for UHA's participating providers. This service allows you to view the **status of your claims or a prior authorization request for medical services,** perform a **simplified member eligibility search** by name and date of birth, view, save or print your **remittance advices**, upload **notes for EDI submitted claims,** or **request an on-site visit**.

To access this feature, you will need to **register for a secured password** with UHA. To register, complete and submit the Online Provider Services Agreement form and the Online Provider Services User Registration form to UHA at uhahealth.com/forms#providers

On-Site Visit Requests

UHA's Outreach Liaisons are available to meet with you to help you or your office staff further understand subjects including, but not limited to:

- Billing/Claims
- Contracts
- Electronic Claim Submisision
- Electronic Payments/EFT
- Fee Schedule
- Online Tools/Forms
- Prior Authorizations

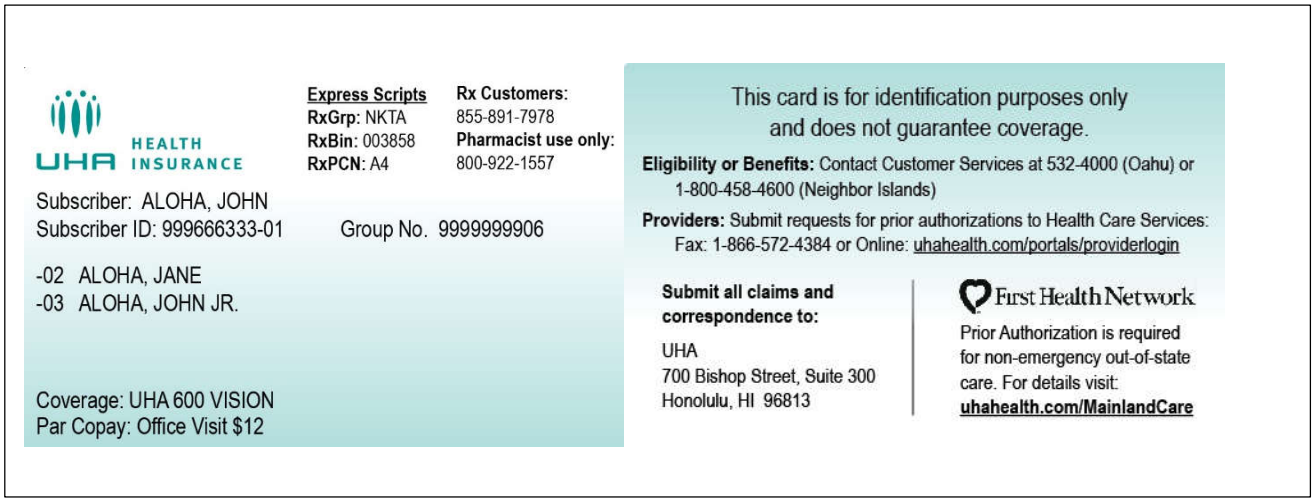
You may request a visit from one of UHA's Outreach Liaisons by logging into the Online Provider Services web portal at uhahealth.com/providerportal, or by simply calling UHA's Customer Services at 532-4000.

Member Eligibility (Not using the Online Provider Services)

There may be occasions when you wish to double-check eligibility for a patient. You may confirm a member's eligibility online at uhahealth.com, or by calling UHA Customer Services at 532-4000, or 1-800-458-4600 from the neighbor islands. You will need the member's ID number and date of birth to verify eligibility. If you have access to the Online Provider Services, you will be able to look up the member's eligibility by name and date of birth.

Eligible members should present you with a current UHA Member Identification Card. These cards provide you with several pieces of essential information.

Sample Member Identification Card (For illustration purpose only and may look different)



Employer groups are responsible for providing UHA updated employee membership information. There are occasions when this information is received late, or when an employer wishes to cancel an employee's coverage retroactively to the date he or she left employment. For this reason, we ask you to understand that the eligibility information is subject to change and does not guarantee payment.

Updating Your Provider Record

Updating your provider record is very important. If UHA has incorrect information on file, this may affect timely payment of your submitted claims. If you are listed in the provider directory with incorrect information, it could hamper UHA members' ability to contact you for an appointment. The **Participating Provider Change Form** must be used to notify UHA of any changes in your information on file with us, such as:

- Changing, or deleting participating provider status (Note: A 60-day written notice is required for terminating your UHA Participating Provider Agreement)
- Change or add ABMS approved specialty (with copy of the certification)
- Change of physical location address
- Change of payment/remittance mailing address
- Phone number, fax number, Tax ID number, and/or e-mail address (Note: If Tax ID number and entity name have both changed, a new executed contract is required and will need to be requested from Customer Services. W-9 forms will also need to be updated.)
- Reporting languages spoken by providers and office staff

The Participating Provider Change Form can be completed online at:
portal.uhahealth.com/cforms/home/parchangeform

Adding Additional Providers to a Group

The Participating Provider Add Form is used to add new providers in your practice to UHA's Provider Network under your existing Group Participating Provider Agreement with UHA. Forms submitted without all required documentation indicated on the form will be returned to the provider group requesting the additional information.

The Participating Provider Add Form can be completed online at:
portal.uhahealth.com/cforms/home/paraddform

Electronic Data Interface (EDI) Claims Submission

Submitting claims electronically may allow faster turn-around time and cost savings in time, paper, and postage. To find out if EDI makes sense for you, contact UHA Information Services at 535-5981, or 1-800-458-4600, extension 253, from the neighbor islands. For your convenience, EDI information for UHA providers interested in electronic claims submission is also available online at uhahealth.com/page/provider-claim-submission.

All contracts executed with an effective date of 02/01/2009 or later will be required to sign up for EDI Claims Submission, if the provider's software is compatible.

We are committed to timely and accurate processing of your claims, and encourage claim submission through electronic data interface. There are three simple and secure ways to submit medical claims electronically. You may connect directly to UHA, use a billing or clearinghouse service, or through Hawai'i Xchange Direct Data Entry.

These methods are quick to set up and providers who submit claims electronically may enjoy:

- Faster processing and reimbursement of claims
- Proof of timely submission through electronic acceptance reports
- Reduced number of lost claims
- Reduced costs associated with labor, paper, and postage for claims

Read below to learn more about each method of electronic submission. If you are unsure of which process is right for you, please contact **UHA Customer Services** for assistance.

Hawai'i Xchange Direct Data Entry Claim Submission

The Hawai'i Xchange is a free service for providers to manage their data, operational, reporting, inquiry, and maintenance needs. The benefits of Hawai'i Xchange are as follows:

- Service is free for providers with no monthly setup or connection fees
- Service is web-based, so no software purchase is required
- You connect directly to UHA for uploading claims
- Claims are submitted online to minimize paperwork and processing time
- Rejected claims can easily be edited for resubmission to UHA
- Non-electronic formats (i.e., paper-based claims) are easily transformed into electronic format (DDE)
- Print files and proprietary formats are easily translated into X12 format
- Remittances (835) can be received and viewed (online)
- Pre-formatted and custom reports for your practice can be accessed (online)

To enroll with Hawai'i Xchange, visit their website at: hawaiixchange.com/SignUp.aspx.
hawaiixchange.com/SignUp.aspx

Provider EDI Claims Submission directly to UHA

You must be able to generate a HIPAA 837 formatted claim transaction file to send directly to UHA. Download the **UHA Trading Partner Manual** as your guide to set up your connection (uhahealth.com/page/provider-claim-submission). Then, complete and submit the following forms to **UHA Information Services**.

- **EDI 837P Professional Claim Registration** – required if submitting professional electronic claims
- **EDI 837I Institutional Claim Registration** – required if submitting institutional electronic claims
- **Electronic Trading Partner Agreement** – required, complete and return to UHA. For a group of providers, only one form is required for the group.

The above forms can be found at uhahealth.com/forms#providers under the section titled EDI.

Provider EDI Claims Submission using a Billing or Clearinghouse Service

Additional set up may be required if you are using a billing or clearinghouse service that will be sending the HIPAA EDI 837P or 837I claim transaction files to UHA. If the billing or clearinghouse service is currently submitting EDI claims to UHA, then contact the billing or clearinghouse service to obtain instructions on what UHA requires for EDI claims submission. If the billing or clearinghouse service is NOT currently sending EDI claims to UHA, then the following is required.

1. The requesting provider is responsible for forwarding the provider identification information and UHA 837P or 837I companion document to the billing or clearinghouse service.
2. The requesting provider must contact the billing or clearinghouse service and establish communication between the billing or clearinghouse service and UHA Information Services.
3. At the request of a provider's billing or clearinghouse service, UHA Information Services will implement the submission and testing of the HIPAA EDI 837P or 837I claims transaction test files.
4. After HIPAA compliance testing is completed and approved by UHA, the requesting provider's billing or clearinghouse service will coordinate an effective date for "live" HIPAA EDI 837P or 837I claims transaction file submission to UHA.

National Provider Identifier (NPI)

Providers who utilize EDI Claims Submission are required to file their NPI with UHA by submitting a copy of the NPI Assignment Notice received from the NPI Enumerator. UHA does not require the use of NPIs on the CMS 1500 form, but it is recommended to include it on the form.

Electronic Funds Transfer (EFT) of Provider Payments

You may lower your administrative costs and receive your reimbursements faster by accepting your payments electronically. Choose to have your processed claims payments sent via Electronic Funds Transfer (EFT).

EFT is a safe, secure, and efficient way to receive your claim payments. Your claims will be paid directly to your bank account, and remittance advice forms will be provided to you to help keep track of claims submitted. Best of all, there is no cost for this service.

To apply, complete an Electronic Funds Transfer form, attach a voided check, and mail to:

UHA
Contracting Services
700 Bishop Street, Suite 300
Honolulu, HI 96813

The Authorization for Electronic Funds Transfer (EFT) Provider Form may be downloaded from our website at uhahealth.com/forms#providers. Once we receive your **form and voided check**, it should take approximately 30 days for you to receive payments electronically.

Locum Tenens

When a physician is unavailable due to illness or other short-term absence, the physician may arrange for another physician to cover his or her practice. Whenever possible, coverage should be provided by a UHA participating provider who participates in applicable UHA plans.

When coverage is required for an extended amount of time (4 weeks or more), the physician or group practice must submit written notice to UHA of the intent to use services of a *locum tenens*. UHA covers medically necessary services rendered by *locum tenens* provided that the *locum* is a licensed physician in the State of Hawaii and is temporarily rendering services for a named UHA participating physician, and has not been deemed ineligible for Medicare reimbursement.

Written notification should include the following information:

- Name of *locum tenens*
- Name of the physician for which the *locum tenens* is rendering services
- Specific time period being covered

The *locum tenens* physician does not need a UHA Participating Provider Agreement. The *locum tenens* will perform services under the absent physician's UHA Participating Provider Agreement. In addition, the *locum tenens* name will **not** appear in UHA's directories. Physician extenders cannot provide locum tenens coverage for a physician.

When submitting claims, the *locum tenens* physician will **use the absent physician's UHA Provider Identification Number in block 33b and absent physician's name in box 31 on the CMS 1500 claim form.** Payments will be made to the absent physician or group practice. **In Block 19, please indicate *"locum tenes for [insert name], M.D."***

Please send notification either via mail, email or fax to:

UHA
Contracting Services
700 Bishop Street, Suite 300
Honolulu, HI 96813
Email: contractingservices@uhahealth.com
Fax: (866) 572-4383

MEDICAL SERVICES

Determination of Medical Necessity

UHA pays for services that are covered benefits under the member's health plan and that are medically necessary.

In making the determination of medical necessity, UHA follows the definition established in Hawaii Revised Statute section 432E-1.4. (See description in "Definitions" section of this handbook page 5.)

In order to make determinations of medical necessity, UHA Health Care Services may require prior authorization of certain proposed services, concurrent, or retrospective review of services provided. UHA will not determine medical necessity of a service without first reviewing supporting clinical documentation.

Requirements for Prior Authorization And/Or Advance Notification

Appropriateness of medical services is a decision made between the patient and the physician; however in order to be reimbursed, **all services must be a covered benefit, as well as being medically necessary and appropriate**.

The list of **Services That Require Prior Authorization And/Or Advance Notification** can be found on UHA's website at uhahealth.com/forms#providers, or by calling UHA Health Care Services. (The list of services requiring prior authorization is subject to change at any time without notice.)

A list of Procedures that are considered cosmetic and not a covered benefit is also available on UHA's website at uhahealth.com/forms#providers. This list is also subject to revision without special notice.

Request for Prior Authorization can be obtained using UHA's Online Prior Authorization Tool by logging into the Online Provider Services web portal at uhahealth.com/providerportal.
Please note: A service that may not require prior authorization if performed in Hawaii, may require a prior authorization if performed out-of-state. Therefore, please be familiar with UHA's out-of-state policy before referring any patient out-of-state for services or treatment.

UHA encourages the use of electronic services whenever possible. UHA may require the use of the **Online Prior Authorization Tool** in order to be eligible to receive the reimbursement rates shown in Exhibit 1A of the UHA Participating Group Provider Agreement and the UHA Participating Provider Agreement. The Online Prior Authorization Tool can be accessed by logging into the Online Provider Services web portal at uhahealth.com/providerportaluhahealth.com/forms#providers.

Requirements for Pre-Admission Review

Elective Hospital Admissions

- **72 hours advance notification** is required for elective hospital admissions (including skilled nursing facilities and rehabilitation facilities) when possible. UHA requires notification of emergency and non-elective admissions within one business day of admission.

Chemical Dependency/Substance Abuse Treatment

- **72 hours advance notification** is required for chemical dependency/substance abuse treatment.

To expedite the pre-admission review, when contacting UHA Health Care Services please provide the following information:

- Patient's name
- Member I.D. number
- Admitting physician's name
- Anticipated date of admission, length of stay
- Primary diagnosis necessitating the admission
- Surgical procedure code (if applicable)

Physicians are obligated to participate with UHA concurrent review activities for inpatient care.

Referrals

UHA members enjoy maximum plan benefits when services are rendered by participating providers in the State of Hawaii. When referring UHA members for specialty services, please keep in mind that they will generally have lower out-of-pocket costs if you refer them to other UHA participating providers. Surgeons should consider this factor when arranging for anesthesia or assistant surgeon services. For assistance locating participating providers, please refer to our website or contact our Customer Services department at 532-4000.

Primary Care Physician (PCP) Responsibility

UHA understands and supports the utility, quality and safety in patient care afforded by devoted primary care providers. We support the concept of "medical homes" and while this field evolves UHA seeks to align members with primary care physicians, supports the use of health risk assessments, encourages the use of

all screening studies as recommended by the United States Preventive Services Task Force without co-payment, and works toward measurable health improvement. Good stewardship of health care resources can be efficiently achieved through careful initiation and coordination of specialty care by PCPs, the employment of evidence-based techniques and decisions, and compassionate attention to members and their families. Physicians who have a primary and enduring relationship with members are highly suited to serve these goals. UHA members should be referred to our participating specialists whenever possible. Out-of-state specialty care should result from referral by in-state specialists only after conferring with PCPs.

UHA actively refers members to primary care providers and we ask that you inform us when you can no longer accommodate new patients. Please inform UHA Customer Services if you are not accepting new patients, and we will note this in the Provider Directory.

Ambulatory Surgery Center (ASC) Procedures

Many inpatient procedures may be safely and effectively performed in an ASC without compromising the quality of patient care. These services are eligible for benefit coverage under UHA plans only when performed in an ASC or physician's office, unless the physician has contacted UHA to receive authorization for a more acute setting (i.e., inpatient hospital).

If a physician is recommending that an ASC procedure be done in an inpatient setting, the physician should call UHA Health Care Services for prior authorization. When requesting prior authorization, the physician should outline the medical reasons why the procedure needs to be done in an inpatient hospital setting.

For all other procedures not listed, but proposed to be done in the ASC instead of the physician's office, a request for prior authorization needs to be completed for benefits to be reimbursed. For confirmation of codes, please contact UHA Health Care Services.

To request prior authorizations, call UHA Health Care Services at 532-4006 from Oahu or 1-800-458-4600, extension 300, from the neighbor islands, Monday - Friday from 8:00 a.m. to 4:00 p.m. You may also submit a written request by fax to (866) 572-4384, or by mail, using the applicable **Prior Authorization**

Request and Notification Form or Out-Of-State Services Request Form to the following location:

UHA
Health Care Services
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Exceptions

Prior authorization is NOT required if—

- The procedure is on the ASC list and will be done in an ASC setting or physician's office.

- Services are performed in an Emergency Department.
- The member is already hospitalized.
- The member is undergoing a different procedure in an inpatient setting, and the listed procedure is being done at the same time.

Midlevel Providers

UHA will reimburse by the terms of its payment policy(ies), available on the UHA website, for covered services provided by duly licensed Midlevel Providers, i.e., Physician Assistants (PA-C) and Advanced Practice Registered Nurses (APRN), who practice in accordance with all applicable statutes and regulations.

Services Rendered to Family Members

UHA plans do not cover services rendered by a physician for self-treatment or services provided to members of his or her immediate family with the exception of vision appliances and administration of vaccines, as well as the vaccines themselves. UHA defines "immediate family" as parent, spouse, and child(ren). Refer to the terms in the Participating Provider Agreement, section 3.2.

Service Documentation

Documentation must be clear and readily available to UHA. Medical records may be requested to evaluate for medical necessity, quality, and accuracy of coding.

1. Documentation must support the levels of services as defined by current CPT and CMS guidelines.
2. Rationale for labs, tests, procedures, and unusually frequent follow-up must be clear.
3. To maintain an accurate medical record, documentation must be contemporaneous with the service or completed as soon as practicable after the service is provided.
4. Documentation after a week of the date of service would be rarely acceptable and would require valid reasoning if requested by UHA. Potential exceptions may include documentation that is accurately supplemented and prompted by hand rendered images or photographs created at the time of service.

COMPLETING AND SUBMITTING MEDICAL CLAIM FORMS

General Instructions

To expedite processing, please complete your claims carefully. Clear, accurate information is essential for UHA to process your claims correctly and without delay. The following CMS 1500 claims filing considerations are particularly important:

1. Determine whether your patient is a member of a group administered by UHA by checking the member's eligibility online at uhahealth.com, or by calling UHA Customer Services. Ask your patient, each time he/she visits, if there has been a change in his/her medical coverage. Avoid having the claim returned by making sure that you have the current information filed.

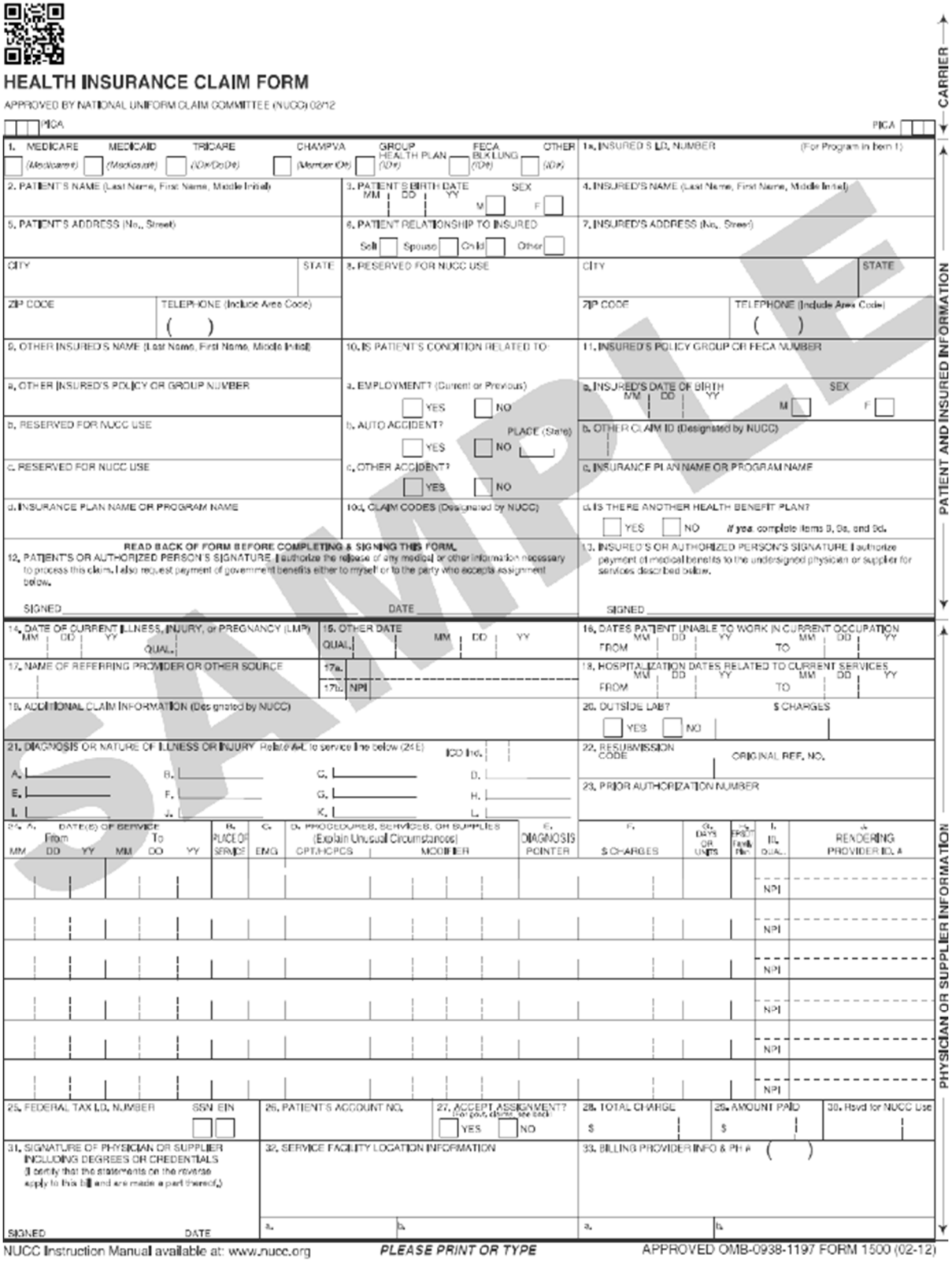
2. Please complete and file a separate CMS 1500 claim form for each patient.
3. The patient **must sign** the claim form authorizing the release of any medical or other information necessary to process the claim, unless your office has obtained a signature on file.
4. When a patient is referred to you for a service, please be sure to enter the name of the referring physician (in last name, first name, middle initial format) in Block 17 of the CMS 1500 claim form. It is especially important to include the name of the referring physician on claims for consultations, physical therapy, and speech therapy.
5. For all CMS 1500 claim forms, please be sure to include the physician's signature or initial, or an authorized agent's signature or initial in Block 31. The name of the physician rendering the service must be indicated legibly, with professional designation, in this field. For *Locum Tenens*, please indicate in Block 19: "Locum Tenens for Dr. [insert name]."
6. When no-fault, workers' compensation, or other third party liability issues are involved, please check the appropriate "Yes" box in Block 10 of the CMS 1500 claim form and list an "E" diagnosis code (describing the place of injury) as the final diagnosis in Block 21.
7. The ICD-9-CM or ICD-10-CM diagnosis code is necessary to be able to determine why specific services were rendered. If this item is missing, you will be sent a "Missing Required Information" letter requesting the necessary information.
8. Be sure to verify the CPT/HCPCS and diagnosis codes entered on the claim form. A simple transposition error can delay the claim's processing or cause it to be processed incorrectly. An itemized statement is required when billing with miscellaneous implant codes. In addition, it is necessary that the diagnosis entered in Column 24E be the diagnosis that corresponds to the medical procedure code entered on that same line in Column 24D. If the diagnosis does not correspond to the medical procedure listed on the same line, payment will be denied for the procedure.
9. It is very important to include your UHA-assigned Provider Identification Number (PIN), in Block 33b of the CMS 1500 claim form. The PIN is necessary to ensure timely and accurate payments. If either the provider's signature or your PIN is missing or illegible, the claim may be returned to you.
10. Mail signed and completed claim forms to:

    UHA
    Attn: CLAIMS
    700 Bishop Street, Suite 300
    Honolulu, Hawaii 96813-4100
11. As a participating provider, payment will be sent directly to you
12. All services billed to UHA through medical claims are supported and documented in the medical record.

Instructions for Completing CMS 1500 Claim Forms

Each number refers to the block/field on the claim form.

Sample CMS 1500 Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Blocks 1 through 13: PATIENT AND INSURED INFORMATION

1 HEALTH CARE PROGRAM
The Group Health Plan box should be checked.

1a INSURED'S I.D. NUMBER
Enter the UHA Member I.D. number exactly as it appears on the member's card.

2 PATIENT'S NAME
Enter correctly spelled patient's name - **Last Name, First Name, Middle Initial.**

3 PATIENT'S BIRTH DATE/SEX
Patient's date of birth by month, day, and year. Place an "X" in the appropriate box for gender.

4 INSURED'S NAME
Enter subscriber's name exactly as if appears on the membership card - **Last Name, First Name, Middle Initial.**

5 PATIENT'S ADDRESS/TELEPHONE
This item will be used as backup information for verifying the previous data, should there be some discrepancy.

6 PATIENT'S RELATIONSHIP TO INSURED
Place an "X" in the appropriate box.

7 INSURED'S ADDRESS/TELEPHONE
This item will be used as backup information for verifying the previous data, should there be some discrepancy. Enter "same as above," if this address is the same as the patient's.

8 RESERVED FOR NUCC USE
This field is not applicable to UHA.

9 OTHER INSURED'S NAME
Enter other insured's name with last name first.

9a OTHER INSURED'S POLICY OR GROUP #
Policy number of the other insured.

9b RESERVED FOR NUCC USE
This field is not applicable to UHA.

9c RESERVED FOR NUCC USE
This field is not applicable to UHA.

9d INSURANCE PLAN NAME OR PROGRAM NAME
Name of the insurance plan for the other insured.

10 IS PATIENT'S CONDITION RELATED TO:
Mark "YES" or "NO" in each box. If "YES" is marked in any box, complete **Block 14** and indicate place and cause of accident or injury in **Block 19**. UHA will compare Block 10 with Block 19 and Block 21 for consistency with the stated injury or illness.

10a EMPLOYMENT
Indicate "YES" or "NO." If "YES," claim should be filed with the workers' compensation carrier.

10b AUTO ACCIDENT
Indicate "YES" or "NO." If "YES," claim should be filed to the No-Fault insurance carrier.

10c OTHER ACCIDENT
Indicate "YES" or "NO." If third party is involved, file claim to third party carrier. Provide place and cause of accident in **Block 19.**

10d CLAIM CODES (DESIGNATED BY NUCC)
This field is not applicable to UHA.

11 INSURED'S POLICY GROUP OR FECA NUMBER
UHA group number may be noted in this box or Block 1a. FECA numbers are not applicable to UHA.

11a INSURED'S DATE OF BIRTH/SEX
If patient is a dependent (non-spouse), enter the insured's birth month and day (MM, DD). Note: Information is needed if patient is a child for Coordination of Benefit determination.

11b OTHER CLAIM ID (designated by NUCC)
This field is not applicable to UHA.

11c INSURANCE PLAN NAME OR PROGRAM NAME
This field is not applicable to UHA.

11d IS THERE ANOTHER HEALTH BENEFIT PLAN?
Enter "YES" or "NO" for **Block 11d.** If "YES," then complete the information in **Block 9.**

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
Enter "Signature of File," "SOF," or legal signature. When legal signature, enter date signed in 6-digit (MM|DD|YY) or 8-digit format (MM|DD|YYYY) format. If there is no signature on file, leave blank or enter "No Signature of File."

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
This field is not applicable to UHA. UHA does not accept assignment of benefits. UHA makes payment only to members and participating providers.

Blocks 14 – 33: PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP)
Month, day and year first symptoms of this spell of illness appeared; for accident give accident date; for maternity give LMP (last menstrual period). Enter the applicable qualifier to identify which date is being reported:
431 - Onset of Current Symptoms or Illness
484 - Last Menstrual Period

15 OTHER DATE
Enter another date related to the patient's condition or treatment. Enter the applicable qualifier to identify which date is being reported:
454 - Initial Treatment
304 - Latest Visit or Consultation
453 - Acute Manifestation of a Chronic Condition
439 - Accident
455 - Last X-ray
471 - Prescription
090 - Report Start (assumed Care Date)
091 - Report End (Relinquished Care Date)
444 - First Visit or Consultation

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
This field is not applicable to UHA.

17 NAME OF REFERRING Provider OR OTHER SOURCE
Enter name (first name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.
If multiple providers are involved, enter one provider using the following priority order:
1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do no use periods or commas. A hyphen can be used for hyphenated names.
Enter the applicable qualifier to identify which provider is being reported to the left of the vertical, dotted line:
DN - Referring Provider
DK - Ordering Provider
DQ - Supervising Provider

17a I.D. NUMBER OF REFERRING PHYSICIAN
For the name given in Block 17, enter the UHA provider number (UPIN), if known.

17b NPI OF REFERRING PHYSICIAN
For the name given in Block 17, enter the NPI, if known.

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

Enter the inpatient hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

19 ADDITIONAL CLAIM INFORMATION

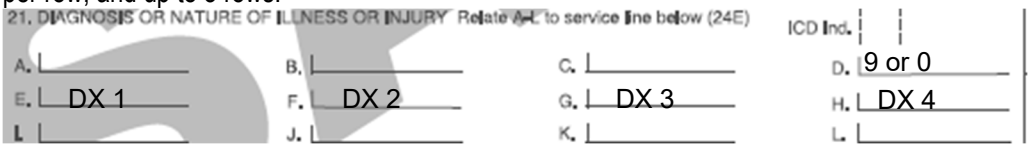
If Block 10 a., b., or c. is answered yes, enter the place and cause of injury (required) OR if locum tenens provided service, please indicate locum tenens name and the name of the physician the locum is representing.

20 OUTSIDE LAB/CHARGES

Place an "X" in the appropriate box.

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – ICD INDICATOR

Use the ICD-9 or ICD-10 code for each current diagnosis applicable to that visit. Do not put any description for each diagnosis code. Codes are to be entered in the correct order following the alphabetical reference numbers (A-L) – codes are entered left to right (alphabetical order), 4 codes per row, and up to 3 rows.



UHA recommends that the diagnosis reference letters (A-L) be used in **Column 24E** to correspond with the services.

"ICD IND" Use this space to indicate if the diagnosis codes being used are ICD-9 or ICD-10 codes. An indicator of 9 would represent ICD-9 codes and a 0 indicator would represent ICD-10. This is a required field.

22 RESUBMISSION

This field is not applicable to UHA.

23 PRIOR AUTHORIZATION NUMBER

Enter prior authorization number assigned by UHA for the current services, if applicable.

24A DATES OF SERVICE

Dates of service for each procedure, using the "From and To" date portion. Indicate only one service per line. If grouping services, the place of service, procedure code, charges and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24G

24B PLACE OF SERVICE

Enter the two-digit POS code specified by UHA for each procedure. (See below).

POS #	Place of Service Description
01	Pharmacy
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgical Center, includes Surgical Center at Outpatient Hospital Facility
25	Birthing Center
31	Skilled Nursing Facility
32	Nursing Home / Nursing Facility
34	Hospice
41	Ambulance (Land / Ground)
42	Ambulance (Air or Water)
53	Community Mental Health Center
55	Residential Treatment Center / Substance Abuse
62	Comprehensive Outpatient Rehab Facility
65	Independent Kidney Disease Treatment Center

81 Independent Laboratory
99 Other

24C EMG (Emergency Indicator)
This field is not applicable to UHA.

24D PROCEDURES, SERVICE OR SUPPLIES
Enter the procedure code for each service, followed by the two-digit modifier when applicable. Tax may be indicated on one of the lines in **Block 24D**, using procedure code **S9999**. Payment made by other carriers and provider adjustment for other carriers should be indicated in Box 29, (See instructions below).

24E DIAGNOSIS POINTER
Enter the diagnosis code reference letter (A-L) from Block 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.

24F CHARGES
Enter the charges for each listed service. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

24G DAYS OR UNITS
Enter the number of days or units, most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume.

24H, 24I & 24J Not applicable to UHA

25 FEDERAL TAX I.D. NUMBER
Enter the Federal Tax ID Number or SSN on which UHA will report payment on the IRS 1099 form. Claims missing this field will be returned to the Provider. Note: This should match what is on your W-9 submitted to UHA.

26 PATIENT'S ACCOUNT NUMBER
If you include your patient's account number, this information will be entered on the participating provider's remittance advice.

27 ACCEPT ASSIGNMENT
This field is not applicable to UHA. UHA does not accept assignment of benefits. UHA makes payment only to members and participating providers.

28 TOTAL CHARGE
Total of all charges on the claim from **Column 24F**. Include the charges for each procedure or service and **Tax**. Do not subtract payment made by other carriers and provider adjustment for other carriers.

29 AMOUNT PAID
Enter all payments made by all other carriers and all provider adjustments required by other carriers. Do not include patient payments. Attach copies of payment by primary payer.

30 Reserved for NUCC Use
This field was previously used to report “Balance Due.” “Balance Due” does not exist in 5010A1, so this field has been eliminated.

31 SIGNATURE OF PROVIDER OR SUPPLIER
Provider or an authorized agent must provide a legible signature or initial here. If a signature stamp is used, it must be initialed by an authorized agent with signature on file at UHA. **The name of the provider rendering service must be legible and indicated in this field.** Claims missing this field will be returned to the Provider.

32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
Name and address of the facility where services were rendered, if other than office.

33 PHYSICIAN'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE
Provider's name and payment address.

33a PHYSICIAN'S NPI NUMBER
Not required by UHA

33b PHYSICIAN'S PROVIDER IDENTIFICATION NUMBER (Supplied to you from UHA)

Please enter your UHA Provider Identification Number in the bottom right corner**.** If you have any questions or need to obtain you Provider Identification Number, please call the UHA Customer Services department at 522-2268. Claims missing this field will be returned to the Provider.

To ensure prompt payment, please be sure to complete all sections listed. Please note that these instructions are only for CMS 1500 claim forms and not for EDI claims submission. Submitting claims that are missing any of the items listed above may result in the claim being returned to the provider.

ClaimCheck® Coding Editor Program

UHA has been licensed to use a version of the McKesson HBOC ClaimCheck® product to automate our review of claims on a prepayment basis for industry standard claims coding. ClaimCheck® contains specific auditing logic designed to evaluate professional billing for Current Procedural Terminology (CPT) coding appropriateness. Automated reviews are more efficient resulting in lower administrative costs, faster claims turn around time, higher consistency and fair adjudication of claims.

UHA updates ClaimCheck® annually with new coding based on current industry standards.

ClaimCheck® Edits

Providers should follow **CPT coding guidelines** to prevent claim denials due to ClaimCheck® editing. Any edits made by ClaimCheck® will be explained by a message on the Provider Remittance Advice.

ClaimCheck® includes the following edit categories:

- Procedure Unbundling
- Incidental Procedures
- Mutually Exclusive Procedures
- Assistant Surgeon Requirements
- Age Conflicts
- Gender Conflicts
- Alternate Code Replacements
- Cosmetic Procedures
- Unlisted Procedures
- Modifier Auditing
- Duplicate and Bilateral Procedures
- Preoperative (preop) and Postoperative (postop) Auditing Billed
- Diagnosis to Procedure appropriateness
- Third Party Liability claims
- Intensity of Service

Providers are not permitted to bill UHA members for denied services unless the service is not a covered benefit of the plan and it is made known to the patient that they will be responsible for the charges, e.g., Cosmetic Procedures.

Advance Financial Notice to Members

Providers are expected to issue the UHA Advance Financial Notice to members prior to initiating a service they should have reason to believe is of a noncovered nature. If such notice is not given, providers may

not shift financial liability for such items or services to members when the claim is denied. Moreover, the participating provider shall refund the member any copayment previously collected.

The notice is available on UHA's website as Advance Financial Notice at uhahealth.com/forms#providers.

Most Common Reasons for Returned Claims

Processing your claims in a timely manner is a goal that UHA strives to maintain. In order to accurately determine plan benefits, it is necessary that the claim form be filled out completely and correctly.

To assist you in completing your claims, we have listed critical areas on the claim form that, if not correctly completed, are the most common reasons for a delay in processing time:

- Subscriber's Name
- Subscriber's Member ID Number
- Patient's Name and Date of Birth
- Date of Service
- UHA Group Number
- Name of Referring Physician for claims from laboratories, radiologists, and consultants
- Date, Place, and Cause of Injury
- Descriptive Diagnosis and ICD-9 code
- Descriptive Procedures and CPT code
- Charges
- Procedure is not appropriate for the diagnosis submitted
- Provider's Billing Name and Address
- Provider or Agent's Signature
- Provider's Identification Number (PIN)

Note: Always submit claims with the UHA Provider Identification Number (PIN) assigned to the rendering Provider. This will ensure that payments are sent to the correct payee and address.

Deadline for Filing Claims

It is important to file your claims on a timely basis. Medical claims that are not filed within one year of the date of service are not payable by UHA or the member. These time frames also apply when UHA is your patient's secondary insurance carrier. An exception may be made to the one-year filing time limitation when UHA is secondary to Medicare. In such case, you must file your claim for secondary benefits within one year of the date Medicare paid or denied the claim. **Note: Claims that were submitted and rejected by UHA for rendering provider not being added to group, can be resubmitted up to one year from the date the initial claim was rejected.**

Timely Claim Filing Waiver Guidelines

The Timely Claim Filing Waiver Form for Providers must be submitted within one year of the date you were informed of initial payment or denial of the claim.

Acceptable reasons for requesting timely filing waivers:

- Claim submission within 12 months from date of service

- Claim submission within 12 months from date of denial
- Claim submission within 12 months from newborn enrollment
- Claim submission within 12 months from primary carrier's payments
- Claim submission within 12 months of third party liability payer exhaust denial (must provide dated denial)

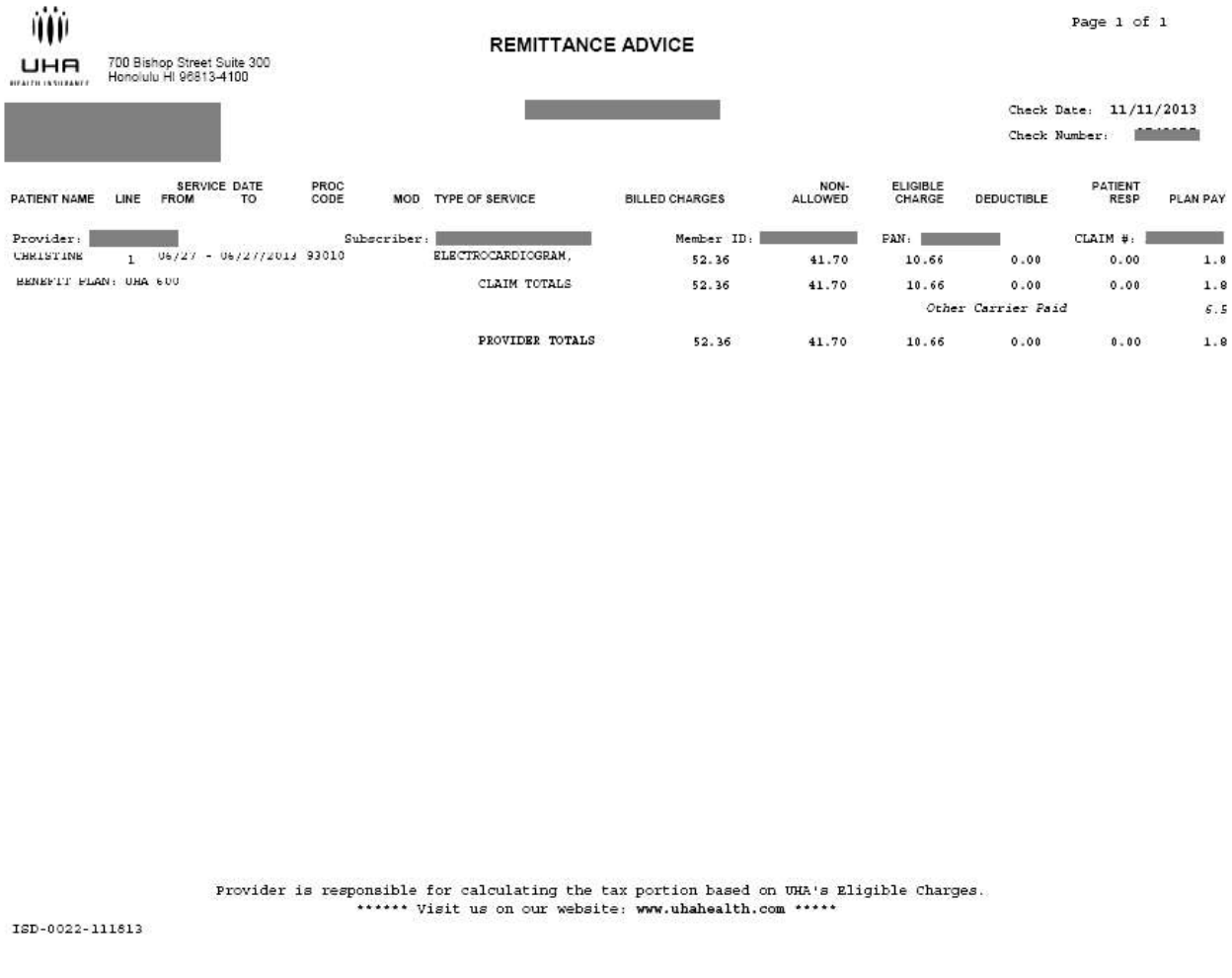
If none of the above reasons apply, a Timely Claim Filing Waiver Form for Providers needs to be submitted with one of the following documents that support attempts of earlier claims submissions:

- Copy of the electronic claim denial/rejection notification
- Dated correspondence from UHA with claim information detailing why claim was rejected
- Dated confirmation of claim receipt

NOTE: When requesting a waiver, please use the Timely Claim Filing Waiver Form for Providers located at uhahealth.com/forms#providers

Remittance Advice

Participating providers will receive a Remittance Advice with each payment of claims. See sample below.



UHA
700 Bishop Street Suite 300
Honolulu HI 96813-4100

REMITTANCE ADVICE

Page 1 of 1

Check Date: 11/11/2013
Check Number:

PATIENT NAME	LINE	SERVICE DATE FROM	TO	PROC CODE	MOD	TYPE OF SERVICE	BILLED CHARGES	NON-ALLOWED	ELIGIBLE CHARGE	DEDUCTIBLE	PATIENT RESP	PLAN PAY
Provider:						Subscriber:		Member ID:		PAN:		CLAIM #:
CHRISTINE	1	06/27	- 06/27/2013	93010		ELECTROCARDIOGRAM,	52.36	41.70	10.66	0.00	0.00	1.8
BENEFIT PLAN: UHA 600						CLAIM TOTALS	52.36	41.70	10.66	0.00	0.00	1.8
											Other Carrier Paid	8.5
						PROVIDER TOTALS	52.36	41.70	10.66	0.00	0.00	1.8

Provider is responsible for calculating the tax portion based on UHA's Eligible Charges.
****** Visit us on our website: www.uhahealth.com *****

ISD-0022-111813

The following is a description of the information contained on the Remittance Advice:

PROVIDER NAME and ADDRESS	The provider who the check is payable to and the mailing address of that provider (up to four lines).
PROVIDER ID	Your tax identification number reported on tax form 1099.
PROVIDER	The physician who performed the service(s). Sometimes different from the check issued payable to.
SUBSCRIBER	The subscriber name associated with this claim.
MEMBER ID	The unique Member I.D. number associated with this claim.
PAN	The Patient Account Number assigned by the provider.
CLAIM #	The Claim I.D. number assigned by UHA to this payment.
PATIENT NAME	The first name of the patient associated with this claim.
SERVICE DATE FROM	The first day of service for the line item.
SERVICE DATE TO	The last day of service for the line item.
PROC CODE	The procedure code for the line item.
MOD	The modifier code for the line item.
TYPE OF SERVICE	The abbreviated description of the procedure code.
BILLED CHARGES	The charges submitted by provider.
NON-ALLOWED	The provider's billed charges less UHA's eligible charge or a billed charge that is not a covered Plan benefit.
ELIGIBLE CHARGE	The dollar amount used to calculate the benefit payment.
DEDUCTIBLE	The dollar amount that is the obligation of the subscriber or member before benefits are payable by us.
PATIENT RESP	The dollar amount the subscriber pays as their share of the eligible charge (co-pay and/or coinsurance).
PLAN PAY	The amount approved to be paid based on the subscribers policy. This is the eligible charge less the member's co-pay/coinsurance or deductible.
OTHER CARRIER PAID	Amounts received by the provider as paid by another insurance carrier.

Remember that as a participating provider, **it is your responsibility to calculate the tax portion to be billed to the patient based on UHA's eligible charge, not the billed amount**.

Coordination of Benefits

If the patient is eligible for benefits under another medical plan, and that plan has the primary responsibility for coverage, a statement showing benefits paid under the primary plan must be submitted with the claim form before processing will begin.

When you receive a payment from the primary carrier and your patient is also covered by a plan administered by UHA, your cooperation in providing the statement of benefits paid by the primary carrier will expedite processing of the claim. Please attach this statement to your claim and send both to UHA.

Coordination of Benefits (COB) is employed when a member has health care coverage from more than one source. Using the order of benefit determination guidelines recommended by the National Association of Insurance Commissioners (NAIC), UHA determines the primary and secondary plans and coordinates benefit payments between the plans.

The following guidelines apply when a patient has more than one group health benefit plan:

- The plan that covers the patient as the subscriber or policyholder is the primary payer.
- If a child is covered under both the mother's and father's plan, the plan of the parent whose birthday occurs first in a calendar year, is the primary payer. (If both parents have the same birth year, month and day, the plan with the earlier effective date is the primary payer.)
- If a member is the subscriber of more than one plan, the plan with the earlier effective date is the primary payer.
- Benefits will coordinate to a maximum of 100% of UHA's eligible charge in accordance with the member's benefit plan.

Note: Coverage for dependent children of divorced or separated parents is determined in accordance with special rules. If you have any questions about these coverage rules, please call UHA's Customer Services department at (808) 532-4000, or from the Neighbor islands call 1-(800)-458-4600.

For a patient with two UHA plans, please indicate the patient's primary UHA number in Block 1a of the CMS 1500 claim form. Mark "YES" in Block 11d and include the patient's other UHA number in Block 9a, along with the required information for Blocks 9 and 9d.

After primary UHA payment has been received, **submit a secondary claim with the patient's secondary UHA number in Block 1a and attach UHA's primary payer Remittance Advice**.

UHA and Medicare

When a member is covered by both a UHA group plan and Medicare, it is necessary to determine which coverage is primary before benefits can be paid. The order of benefit determination guidelines does not apply when one of two medical plans is Medicare. Instead, Medicare Secondary Payer (MSP) rules apply. Or, if a person qualifies for Medicare because of end-stage renal disease (ESRD), a special set of rules applies.

If you believe UHA will be the primary payer according to the guidelines below, please file the claim promptly after services are completed. If you think UHA is the secondary payer, please send the claim to the primary payer first.

Qualifying for Medicare

People qualify for Medicare due to any one of three situations: age, disability, or ESRD. The following are conditions that apply to each of the three qualifying situations and affect coordination of benefits:

1. Age (for recipients age 65 or older) - The UHA plan is primary if all of the following conditions are true:
   - The patient has Medicare Part A, or Parts A and B.
   - The subscriber of the UHA group plan is actively employed by his or her company and is covered under the employer's group plan (i.e., contributes to FICA).
   - The subscriber's employer has 20 or more part-time or full-time employees.

2. Disability (for recipients younger than 65 who qualify because of a disability but who have not been diagnosed with chronic renal failure): The UHA plan is primary if all of the following conditions are true:
   - The patient has Medicare Part A, or Parts A and B.

- The subscriber of the UHA group plan is actively employed by his or her company and is covered under the employer's group plan.
- The subscriber's employer has 100 or more part-time or full-time employees. If the group insurance is a multi-employer plan, such as a union plan that covers employees of various companies, then this condition is met if at least one company in the group has 100 or more employees.

3. End-Stage Renal Disease (ESRD): For recipients who are younger than 65 but qualify because they have been diagnosed with ESRD, Medicare establishes an "'ESRD date" that is the first of the month in which the patient was diagnosed with chronic renal disease and a shunt is inserted.

Medicare ESRD Rules

- The UHA group plan is primary for 30 months from the ESRD date. For example, if the shunt was inserted on 9/1/97, then the Group Health Plan is primary from 9/1/97 to 2/28/2000. Medicare Part A is primary effective 3/1/2000. Part B is also primary effective 3/1/2000.
- If a kidney transplant is done, Medicare is primary for 36 months (3 years).
- If the transplant is successful, then the member is dropped from Medicare Part A after 36 months.
- If the transplant fails and the member needs dialysis again, Medicare Part A continues.

If you believe that UHA is the primary payer, please file the claim to UHA after services are completed. If UHA is the secondary payer, please send the claim to the primary payer first and submit the claim along with the other health plan's remittance advice for secondary payment from UHA.

For a patient with UHA health plan and another health plan, please mark YES in Block 11d of the CMS 1500 claim form and include the patient's other policy number in Block 9a, along with the required information for Blocks 9and 9d (other insured's name, and insurance plan or program name).

If another carrier has made any payment for the services you are claiming, please attach the other carriers explanation of benefits paid (e.g., EOB) to the claim. Always report your full Total Charge amount in Block 28.

Motor Vehicle Insurance - No-Fault Benefits

Any motor vehicle insurance coverage will be considered the primary plan and its benefits will be applied first. If a third party caused the motor vehicle accident and the injured member is eligible to recover damages pursuant thereto, any benefits for which the member may be eligible shall be subject to the provisions under the Third Party Liability section of the member's Medical Benefits Guide.

When the patient exhausts his or her no-fault benefits, the patient or physician must notify UHA. Upon notification, we will send the member an Accident Information Form and ask that the form be completed and returned to us with the following documents before any remaining claims relating to the motor vehicle accident can be processed:

- A letter from the no-fault carrier stating that the no-fault benefits have been exhausted; and
- A recap or summary from the no-fault carrier listing all of the medical expenses that the motor vehicle insurance covered according to the date on which the expenses were incurred.

UHA's rights of reimbursement require that any benefits paid in third party liability situations be repaid from any recovery received by a member as a result of the third party injury or illness.

Workers' Compensation

UHA is not responsible for reimbursement of medical claims for which a third party is responsible. Such claims include services for a work-related injury or illness, which are covered by the patient's employer's Workers' Compensation insurance.

Payment Denial by Workers' Compensation Carrier

The patient or physician must notify UHA if the Workers' Compensation insurance denies payment. Upon notification, we will send the member an Accident Information Form and ask that the form be completed and returned to us with a copy of the denial letter from the Workers' Compensation carrier. Claims payment will be based on the following guidelines:

- **If there is a State of Hawaii determination that illness or injury is work-related**
  UHA will not pay any related medical claims. Claims should be paid by the employer's Workers' Compensation carrier. If the employer appeals the determination, the employer's Workers' Compensation should continue to pay until a decision is rendered on the appeal.

- **If there is a State of Hawaii determination that illness or injury is not work-related**
  If the member does not appeal the determination, UHA will pay the related medical claims. If the member does appeal the determination, UHA will pay for all covered services until a decision is rendered on the appeal.

If UHA pays benefits for services that should have been billed to Workers' Compensation, UHA will seek reimbursement from the participating provider. All claims paid by UHA are subject to member eligibility at the time of service, UHA's guidelines for medical necessity, and the provisions and limitations of the member's plan. Please be advised that under Hawaii state law and your Participating Provider Agreement with UHA, you may not bill the insured for the balance of any payment made on this claim.

Third Party Liability

Third party liability (TPL) situations occur when a member is injured or becomes ill and:

- The injury or illness is caused, or alleged to have been caused, by someone else and the member has, or may have, the right to recover damages or receive payment in connection with the illness or injury; or
- The member has, or may have, the right to recover damages or receive payment from someone else for the member's illness or injury, without regard to fault.

Claims that are submitted with a possible TPL diagnosis are pended for review. Please state the cause and place of injury in Block 19, Additional Claim Information (Designated by NUCC), of the CMS 1500 claim form. If no cause or place of injury is stated on claim, the claim may be denied with message, "Cause and place of injury required. Please resubmit claim."

If the member has or may have coverage under Workers' Compensation insurance, such coverage will apply instead of coverage under UHA's plan. Medical expenses arising from injury or illness covered under Workers' Compensation insurance are excluded from UHA plan coverage. If a motor vehicle accident is

involved, motor vehicle insurance personal injury protection benefits must first be exhausted before health plan benefits may apply.

Prior to the payment of plan benefits, UHA may require that the member complete and sign certain forms in a third party liability situation as described in the member's Medical Benefits Guide. Failure of the member to comply may result in delay in payment or denial of related claims.

CLAIMS REVIEW AND APPEALS

Requesting Reconsideration of a Claim for Payment

If you believe a claim should not have been denied or if you disagree with the amount of the payment, please call 532-4000 Ext. 351 to speak with a Customer Services Representative to initiate a review. Requests must be made within one year of the date you were informed of initial payment or denial of the claim. Be sure to have the following information available when you call:

- Member name
- Member I.D. number
- Rendering provider's name
- Date of service
- Total amount billed
- Succinct description of your dispute

A preliminary reconsideration may result in a request for additional information. UHA will expedite both the request and the review.

When the review has been completed, we will either reprocess the claim, in which case you will receive a new Remittance Advice, or we will inform you why we believe our original determination was correct. If the matter is not resolved to your satisfaction, you may appeal the decision as described in the "Appeals Process" section.

You may also request a reconsideration of a claim by mailing or faxing a Provider Claims Action Request form to Customer Services. This form can be found on UHA's website at the following address: uhahealth.com/forms#providers

Requesting Reconsideration of a Utilization Management (UM) Denial

If you are dissatisfied with a denial which was based in whole or in part on a medical judgment, including determinations of whether a procedure was experimental or investigational, or whether it was medically necessary or appropriate, your informal reconsideration is limited to a peer-to-peer clinical review (telephonic, in person, or electronically) between UHA and the treating provider. For a peer-to-peer clinical review, please call UHA's Health Care Services department at 532-4006 or from the Neighbor islands, 1-800-458-4600. Requests for a peer-to-peer clinical review must be made within one month of the date you were informed of the adverse decision.

Incorrect Payments

There may be times when you discover that UHA made a payment error caused by either a billing error (e.g., incorrect code submission or no PIN information), or an adjudication error (e.g., data entry error). When these types of errors occur, please notify UHA's Customer Services department by calling 532-4000 or from the neighbor islands, 1-800-458-4600.

If you received an incorrect payment due to UHA's error, you may:

1. Mail either the original check or a check to UHA for the original incorrect amount. With the check, please enclose either a copy of the Remittance Advice with a reason for returning of funds, or a legible statement including the following information with the check to ensure proper adjustments to your account:

   Patient name
   UHA Provider Identification Number
   Date of service
   Reason the payment is being returned

2. Contact UHA Customer Services to report the error and ask that a deduction for the incorrect payment be made on your next Remittance Advice. UHA will then recoup the overpayment through take-backs from future payments.

Requesting a Fee Increase for Vaccinations

A provider may ask UHA to review a specific request for an increase in a vaccination fee by submitting a written request and a copy of the manufacturer's invoice for the vaccine in question.

A request for a fee review is initiated when both the written request and a copy of the invoice are received by the Contracting Services department. Providers may also submit a request by completing the Vaccination Fee Review Request Form. This form is available online at uhahealth.com/forms#providers**.**

Upon receipt of the requested information, UHA Contracting Services will analyze and process the fee request. Contracting Services will communicate its decision to the provider in a timely manner.

There will be no retroactive adjustments. Providers that bill vaccines through ESI must contact and work directly with ESI for fee increase requests.

To initiate a review, please submit your written request to:

Mail: UHA
Contracting Services Department
700 Bishop Street, Suite 300
Honolulu, HI 96813
Email: contractingservices@uhahealth.com
Fax: (866) 572-4383

Appeals Process

Standard Appeals

This section shall be used for any disputes as to whether services or supplies are medically necessary or are covered services.

Appeals must be submitted in writing to:

UHA Appeals Coordinator
700 Bishop Street, Suite 300
Honolulu, HI 96813

We must receive your written appeal within one year of the date UHA informed you of the denial or limitation of the claim for payment. Disputes involving administrative matters, such as UHA fee schedules, policies, or interpretation of your Participating Provider Agreement, must be submitted to appeal within one year of your notice of such schedule, policy, or interpretation.
Your appeal should include the following information: the date of your request, your patient's name and member identification number, the date of service you believe we denied or paid in error, or the date of the contested action or decision, a description of the facts related to your appeal and why you believe our action or decision was in error, and any other details about your appeal, including written comments, documents, and records you have relating to your appeal that you would like us to review. You should keep a copy of the request for your records. It will not be returned to you.

You will be provided, upon request and free of charge, copies of all documents, records, and information relevant to the claim for payment, as defined by federal ERISA rules, and any rule, guideline, or protocol we relied upon in making the decision at issue.

Your appeal will be reviewed by staff not involved in the original decision (nor a subordinate to the original decision maker) and will not give deference to the initial decision. If the appeal concerns a matter of medical judgment about an otherwise covered category of service that is not expressly excluded by the member's plan, it will be reviewed by an independent licensed practitioner with appropriate expertise and experience in the field of medicine involved in the medical judgment, and who was not previously consulted in connection with the original decision. The review will take into account all comments, documents, records and other information submitted by you relating to the claim, or considered as relevant by UHA, without regard to whether such information was submitted or considered in the initial benefit determination.

If we consider, rely upon or generate any new or additional evidence in our appeal review, we will provide you, free of charge, that evidence as soon as possible and sufficiently in advance of the date our decision on appeal is due to provide you a reasonable opportunity to respond prior to that date.

If we intend to base our decision on appeal on a new or additional rationale, we will provide you, free of charge, the rationale as soon as possible, and sufficiently in advance of the date our decision on appeal is due, to provide you a reasonable opportunity to respond prior to that date.

If our appeals decision denies your request or any part of it, we will provide an explanation, including an identification of the claim or service denied, the specific reason for denial, reference to the health plan terms on which our decision is based, a statement of your external review rights and other information regarding our denial.

UHA's final internal decision will be made by UHA's Appeals Committee. We will notify you of our decision within 30 days of receipt of your written appeal if your appeal concerns a UHA denial of a prior authorization request, or a UHA denial which was based in whole or in part on a medical judgment, including determinations of whether a procedure was experimental or investigational, or whether it was medically necessary or appropriate. We will notify you of our decision within 60 days of receipt of your written appeal for all other appeals.

Expedited Appeals

You can request an Expedited Appeal (72-hour response time for UHA's final internal determination) if the standard time (30 or 60 days, as set forth above) for completing an appeal would:

- seriously jeopardize the member's life or health;
- seriously jeopardize the member's ability to gain maximum functioning; or
- subject the member to severe pain that cannot be adequately managed without the care or treatment requested.

Expedited appeals are only appropriate when a denial affects care that is in progress or to be initiated. Expedited appeals do not apply to payment denials for services already rendered.

To request an Expedited Appeal, call UHA Health Care Services at 808-532-4006, 1-800-458-4600, extension 300, from the neighbor islands, or fax the request to 866-572-4384. All necessary information regarding such appeal may be submitted by facsimile, or other expeditious means.

Binding Arbitration for Contesting Appeal Decisions

If you wish to contest our decision on any appeal, you must agree to binding arbitration. To request binding arbitration, you must submit a written request for arbitration to UHA within 60 days of the date of the letter communicating the decision of the Appeals Committee. Both parties will agree on the person to serve as the independent arbitrator. The decision of the arbitrator is binding on both parties. Costs for the arbitration will be shared as ordered by the arbitrator. Further details are provided in your Participating Provider Agreement.

Provider Dispute Resolution

The participating provider and UHA will work together in good faith to resolve any and all disputes between them as to:

- Issues arising under or related to the UHA Participating Provider Agreement.
- A participating provider's status within the provider network.
- Any action by UHA related to a provider's professional competency or conduct.
- Issues related to any conduct, act, or omission by UHA.

A provider dispute must be submitted in writing by certified mail, return receipt requested, to:

Attn: Contracting Services
UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813

Your letter must contain the following information:

1. A clear and concise description of the nature of the complaint and how the UHA action violates the Participating Provider Agreement;
2. The specific remedy requested for resolution; and
3. All evidence and documentation supporting your position and the action you desire from UHA.

For all medical necessity issues refer to the prior Appeals Process section.

If the participating provider and UHA are unable to resolve their dispute then resolution may be obtained solely through binding arbitration.

Binding Arbitration for Provider Dispute Resolution

If the parties are unable to resolve their dispute within 60 days following the date one party sent written notice of the dispute to the other party, and if either party wishes to pursue the dispute, then the dispute shall be submitted to binding arbitration. Both parties will agree on the person to serve as the independent arbitrator. The decision of the arbitrator is binding on both parties. Costs for the arbitration will be shared as ordered by the arbitrator. Further details are provided in your Participating Provider Agreement.

Provider Watch Program

The vast majority of UHA providers strive to comply with their professional and contractual duties at all times. However, UHA occasionally discovers a participating provider who is unwilling to comply with those duties or engages in what appears to UHA as improper billing practices, or clinical procedures that could threaten harm to UHA members. UHA's "Provider Watch Program" uses early intervention with such providers to help protect UHA and its members and seek compliance with provider duties. UHA may, at its discretion, place any provider into its Provider Watch Program if UHA's Chief Medical Officer, Medical Director, (or delegee) determines that the provider meets any one of the following criteria:

- The provider violates any duty owed under the UHA Participating Provider Agreement
- The provider fails to cooperate with UHA in any audit, request for clinical and billing records, utilization management or quality assurance program
- The provider has billing procedures, member complaints, medical practices, or utilization patterns that UHA's Medical Director believes indicate potential violation of any duties owed under the UHA Participating Provider Agreement

For providers who are in UHA's Provider Watch Program, upon written notice to the provider, UHA shall have the right to require the following action(s) by the provider, to protect UHA and its members:

- Obtain prior authorization from UHA before rendering specified services to UHA members (beyond those services that require pre-authorization for all providers)
- Create, maintain, and submit to UHA specified types of clinical and billing records as a condition to receipt of payment of any claims
- Refrain from providing specified services to UHA members (and refer UHA members to appropriate providers for such specified services)
- Inform UHA members being served by the provider of any prior authorization requirements or restrictions in services that will affect UHA members

If a provider demonstrates to UHA's satisfaction that the provider's practices conform to their professional and contractual duties, UHA may remove the provider from the Provider Watch Program. UHA reserves all rights to remove providers from the Provider Watch Program.

Topa Financial Center
Bishop Street Tower
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100
T 808.532.4000
1.800.458.4600