700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
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www.uhahealth.com

Print Form

Out-Of-State Services Request Form

1) *MEMBER INFORMATON:*

Patient Name:	Patient Member Number:	Date of Birth: (MM/DD/YYYY)
Patient Gender: ☐ M ☐ F	Phone Number:	UHA Plan: ☐ 600 ☐ 3000
Other Insurance? ☐ Yes ☐ No	Specify Other Insurance:	Subscriber:

2) *REQUESTING PHYSICIAN / PROVIDER INFORMATION:*

Name:	Specialty:	TAX ID# (Out of State Provider ONLY)
Contact Person:		Phone: Fax:
Address:		
Personal Physician:		Phone: Fax:

3) *SERVICING PROVIDER INFORMATION:*

Name:	TAX ID# (Out of State Provider Only)
Address:	Requested Facility: TAX ID#
Contact Person:	☐ Inpatient ☐ Ambulatory (Outpatient) Surgery Center
Phone: Fax:	☐ Other

4) *CLINICAL INFORMATION:*

Procedure requested:	CPT:	Date of Procedure:
Procedure requested:	CPT:	Date of Procedure:
Procedure requested:	CPT:	Date of Procedure:
Diagnosis Description:	ICD Code:	
Diagnosis Description:	ICD Code:	
Diagnosis Description:	ICD Code:	

Is Patient's Condition Related To An Accident: (Current or Previous)? ☐ Yes ☐ No

If Yes - Check one of the following: ☐ Employment ☐ Automobile ☐ Home ☐ Other (specify)

SUBMIT THIS SIGNED AND COMPLETED FORM ALONG WITH SUPPORTING CLINICAL DOCUMENTATION

Physician Acknowledgment:
I have read and understand the definition of Medical Necessity outlined in Hawaii Revised Statutes 432E-1.4. (see back of sheet). I further understand that UHA applies this definition to the authorization and payment for all services rendered to its members. I, or my agent acting on my behalf, attest that the services requested above meet the definition of medical necessity

_____ _____
Signature of Physician or Agent REQUIRED Date

INSTRUCTIONS FOR SUBMITTING THIS FORM

Prior Authorization and Notification Forms
may be downloaded from our website: www.uhahealth.com

Prior Authorization is a special pre-approval process to ensure that certain treatments, procedures, or supplies are *medically* necessary Covered Services that will be provided in an appropriate setting. This is not an authorization for payment. Payments are made subject to member's eligibility and benefits on the day of service.

In determining whether to provide Prior Authorization, we may use guidelines that include clinical standards, protocols, or criteria regarding treatment of specific conditions or providing certain services or supplies.

Submit a completed Prior Authorization Request and Notification Form

a) along with supporting clinical documentation (e.g. clinical notes, diagnostic studies, lab results) to the Health Care Services Department via fax (866) 572-4384 or by mail:

UHA
Attention: Health Care Services Department
700 Bishop Street, Suite 300
Honolulu, Hawaii 96813

b) You must provide sufficient information to allow us to make a decision regarding your request. If you do not provide the information we request, or if the information you provide does not show entitlement to coverage under the member's plan, your request may be delayed or denied.
c) This is not an authorization for payment. Payments are made subject to member's eligibility and benefits on the day of service.
d) This form is also used for all out-of-network referrals.

In clinically urgent situations prior authorization determinations are made within 72 hours. Routine prior authorization determinations are made within 15 days.

All Out of State referrals require at least 15 days advance prior authorization notice.

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[1]HRS 432E-1.4. Medical Necessity. (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 ay be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity. 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 licensed health care provider and 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. Effectiveness is determined first by scientific evidence; if no scientific evidence exists then by professional standards of care; 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 this condition compared to alternative health interventions, including no intervention. For purposes of this section, cost effective shall not necessarily mean the lowest price.

Required Attachments For Out Of State Prior Authorization Requests

UHA's service area is the State of Hawaii. If this is a request for services OUTSIDE the State of Hawaii, please complete this form in addition to the Out-Of-State Services Request Form

Services outside the State of Hawaii are being requested for the following reason: (check one)

☐ Patient is requesting services that are available in the State of Hawaii and has been advised that out-of-state care for services that are available in the State of Hawaii may result in a substantially higher patient cost.

☐ Medically necessary services are NOT available in Hawaii. Pertinent medical documents are attached. Please check below as appropriate.

☐ Patient has been seen by the following specialists: (list with specialty)

1. _____
2. _____
3. _____
4. _____
5. _____

☐ Specialist(s) report(s) attached.

☐ Patient has been seen for a second opinion who concurs that service is not available in Hawaii.

Name of physician: _____ Specialty:_____

☐ Requested procedure is not performed in Hawaii. Supporting documents related to proven medical outcomes and cost effectiveness is attached

FDA approved ☐ yes ☐ no

Clinical trial ☐ yes ☐ no If yes, specify:

☐ Consultation only. Treatment will be provided in Hawaii.
Note: Any diagnostic workup requires prior authorization

☐ Transplant services as noted on prior authorization request form.

I have discussed the following with my patient.

☐ Travel plans SHOULD NOT be made until authorization is obtained.

☐ Travel and lodging expenses ARE NOT covered benefits.

Please note: At least 15 days is required for Out of State requests.

_____
Physician signature