hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

# HMSA PRECERTIFICATION REQUEST

**Please fax completed form to: (808) 944-5611**

Or Mail to: HMSA
Medical Management Department
P. O. Box 2001
Honolulu, Hawaii 96805-2001

Phone Nos: (808) 948-6464 Oahu
(800) 344-6122 Neighbor Island

☐ **Precertification Request*** ☐ **Review of Service(s) Not Requiring Precertification** ☐ **HMO Administrative Review**
(*For HMO members, check HMO Administrative Review box if services are being performed by an In-State Nonparticipating or Out-Of State Provider)

☐ **URGENT Review**

According to the Department of Labor regulations, if we do NOT give you a decision within 72 hours, it could *(at least one of the following must apply.)*

1. Seriously jeopardize the life or health of the member.
2. Seriously jeopardize the ability of the member to regain maximum function.
3. Subject the member to severe pain that cannot be adequately managed without the service(s).

**Physician/RN/LPN signature:** _____ *(if left blank, request will be reviewed based on nonurgent timeframes)*

***To avoid delays, please attach supporting documentation***

## PROVIDER CONTACT INFORMATION

**Any questions or concerns regarding this request may be directed to:**

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

## A. MEMBER INFORMATION

**Membership Number** _____ Patient's Name (Last, First, MI) _____ Date of Birth _____

Subscriber's Name (Last, First, MI) _____ Phone number _____

## B. ICD-9-CM/ICD-10-CM DIAGNOSIS CODE(S)

Diagnosis Code(s): _____ _____ _____ _____

## C. PROCEDURE/SERVICE/TREATMENT INFORMATION

Place of Service: ☐ Inpatient ☐ Outpatient/ASC (Ambulatory Surgical Center) ☐ Labs & Diagnostic Services (Outpatient) ☐ Office ☐ Home

CPT/HCPCS Code(s): _____ _____ _____ _____ _____ _____ _____ _____
*Modifier* *Modifier* *Modifier* *Modifier*

**Service Date(s):** _____ to _____ **Number of Visits/Units Requested:** _____

## D. PROVIDER INFORMATION

**Requesting (or referring) Provider Name** _____ Provider ID _____

Address _____

Phone Number _____ Fax Number _____

**Servicing Provider/Facility/Vendor Name (if different from requesting or referring provider)** _____ Provider ID _____

Billing Address _____

Phone Number _____ Fax Number _____

## E. General Comments

_____

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