HMSA PRECERTIFICATION REQUEST

An Independent Licensee of the Blue Cross and Blue Shield Association

Please fax completed form to: 944-5611

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

Phone no.: 948-6464 Oahu
1 (800) 344-6122 Neighbor Islands

☐ **Precertification request*** ☐ **Review of service(s) not requiring precertification** ☐ **HMO administrative review**

(*For HMO members, check the HMO administrative review box if services are being performed by an in-state nonparticipating or out-of-state provider.)

☐ **Standard request**	**Commercial, Federal and EUTF Plans:** Decision & notification are made within 15 calendar days* **QUEST Integration and Medicare Advantage:** Decision & notification are made within 14 calendar days*
☐ **Expedited request** *(MD, RN or LPN Signature required)*	**All plans:** Decision & notification are made within 72 hours* or as expeditiously as this member's health condition requires, if urgent criteria are met. *By signing below, I certify that following the standard timeframe could seriously jeopardize this member's life or health or ability to attain, maintain, or regain maximum function.* Signature *(if left blank, request will be reviewed based on standard timeframes)* Date signed

**From receipt of request by HMSA, provided that all relevant supporting clinical information and documentation are submitted*

To avoid delays, please attach supporting documents

Provider contact information

Any questions or concerns about this request may be directed to:

Contact name (first and last) Phone no. Fax no.

A. Member information

Membership number Patient's name (last, first, MI) Date of birth

Subscriber's name (last, first, MI) Phone no.

B. ICD-10-CM diagnosis code(s)

Diagnosis code(s): _____ _____ _____ _____

C. Procedure/service/treatment information

Place of service: ☐ Inpatient ☐ Outpatient/ASC (ambulatory surgical center) ☐ Labs and diagnostic services (outpatient) ☐ Office ☐ Home

CPT/HCPCS code(s)	Modifier	# of units	CPT/HCPCS code(s)	Modifier	# of units	CPT/HCPCS code(s)	Modifier	# of units

Service date(s): _____ to _____

D. Provider information

Requesting (or referring) provider name Provider ID

Address

Phone no. Fax no.

Servicing provider/facility/vendor name (if different from requesting or referring provider) Provider ID

Billing address

Phone no. Fax no.

E. General comments