HMSA PRECERTIFICATION REQUEST

Please fax completed form to: (808) 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
1 (800) 877-5394 U.S. Mainland

An Independent Licensee of the Blue Cross and Blue Shield Association

☐ **Precertification request*** ☐ **Review of service(s) not requiring precertification** ☐ **HMO/PPO administrative review**
☐ **Medicare Advantage plan-directed care review** ☐ **Hospital Discharge** _____
Discharge Date

(*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