ALOHACARE TRAVEL REQUEST FORM

Transportation Prior Authorization Fax Line 808-207-0047

☐ Out-of-State / Out-of-Network ☐ On Island ☐ Off Island ☐ Out of State

☐ Standard Request	Requests for prior authorization (with supporting clinical information and documentation) should be sent to AlohaCare 14 days prior to the date of travel.
☐ Expedited Request* ***Physician Signature Required***	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function. _____ Physician Signature Validating Expedited Request _____ Date Signed

Requestor Information

List contact for any questions or concerns regarding this request:

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

Member Information

Member ID Number:	Member Name (Last Name, First Name MI):	Date of Birth:
Member Address (*for Member pick-up location; no PO Box*):		Member Phone Number:

Provider Information

Provider 1	Treating Provider Name:	Appointment Date:	CPT/HCPCS Code/Modifier or Type of Appointment:	Appointment Time & Duration:
	Treating Provider Contact information:	Appointment Address:		Appointment Duration & Treating Provider Confirmed by Requestor: ☐ Yes ☐ No
Provider 2	Treating Provider Name:	Appointment Date:	CPT/HCPCS Code/Modifier or Type of Appointment:	Appt Time & Duration:
	Treating Provider Contact information:	Appointment Address:		Appointment Duration & Treating Provider Confirmed by Requestor: ☐ Yes ☐ No
Provider 3	Treating Provider Name:	Appointment Date:	CPT/HCPCS Code/Modifier or Type of Appointment:	Appt Time & Duration:
	Treating Provider Contact information:	Appointment Address:		Appointment Duration & Treating Provider Confirmed by Requestor: ☐ Yes ☐ No

Additional Comments:

Travel Details

To assure travel accommodations, please indicate members information:		Departure Date:	Return Date:
Type of Travel: ☐ Air ☐ Ferry	Type of Ticket: ☐ One way ☐ Round trip	Departure City/Airport:	Arrival City/Airport:
Medical reason if stay is longer than one day:		Height:	Weight:
Lodging Required? ☐ Yes ☐ No		Wheelchair Accessible Room Required? ☐ Yes ☐ No	

Companion Information

Companion Required? ☐ Yes* ☐ No **If yes, AlohaCare will require Medical Necessity Form & additional 24 hours to process*

Medical Reason for Companion:	Name & Birthdate of Adult Companion (*as listed on valid photo ID*):
Additional Comments:	Height/Weight (*for Mokulele Flights to Molokai/Lanai*):

Ground Transportation

Required Off-Island? ☐ Yes ☐ No	Required on Home Island? ☐ Yes ☐ No Preferred Transportation Provider (*preferred provider not guaranteed*):

Medical Needs

Wheelchair Required? ☐ Yes ☐ No Gurney Required? ☐ Yes ☐ No	Has own wheelchair? ☐ Yes ☐ No If yes, indicate type of wheelchair: Can member transfer? ☐ Yes ☐ No

Additional Comments:

*Authorizations will be given for medically necessary services only: it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergencies do not require prior authorization (An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity that could result, without immediate medical attention, in serious jeopardy to the health of an individual). *Urgent Care is defined as medically necessary treatment for an injury, illness or other type of condition (usually not life -threatening) that should be treated within 24 hours.*