



PRE-CERTIFICATION REQUEST FORM

Pre-certification is for the sole purpose of reviewing the medical necessity of the recommended hospitalization, procedure, treatment, therapy or rehabilitation. Pre-certification is not a guarantee that charges are covered under the Plan. All charges submitted to HMAA are subject to eligibility, all applicable plan provisions and retrospective review. Patients who are ineligible or determined to be ineligible for HMAA benefits at a later time, or who receive healthcare services that are not covered benefits as described in their Summary Plan Descriptions (SPD), are solely responsible for all costs. Cosmetic, experimental or investigational procedures, and "off label" use of pharmaceuticals are not covered by HMAA.

TO:	HMAA Health Management Department	Fax Number: (808) 791-7697	
DATE:		Phone Number: (808) 791-7505 Toll-Free: (888) 941-4622 ext. 302	
FROM:	Contact Person	Phone Number	Fax Number
	Requesting Physician	Phone Number	Fax Number
RE:	Name of Patient	Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Date of Birth (mm/dd/yy) / /
	Name of Subscriber		Member ID Number
Diagnosis (ICD-9 Codes)		Description	
Requested Services (CPT / HCPCS Codes)		Description	
Anticipated Date(s) of Service(s)	Anticipated Date of Surgery (If Applicable)	Anticipated Date of Admission (If Applicable)	
Name of Facility Providing Service(s)	Pertinent Clinical Information/Medical Justification for Requested Service(s)		

Please provide supporting documentation: History & Physical Diagnostic Reports Progress Notes

OUTPATIENT REHAB SERVICES & HOME HEALTH FACILITIES: Please fax a copy of the treatment plan (signed by the requesting physician) with this request form.

HMAA's HM Department will notify you of the pre-certification decision after all supporting information has been reviewed.

HMAA USE ONLY

Authorized By	Authorization Date	Pre-certification #