HWMG
HAWAII-WESTERN MANAGEMENT GROUP, INC.
Third-Party Administrator

☐ **Urgent** ☐ **Non-Urgent**

Precertification Request Form – Medical

This form is to request precertification of **medical** services. To request **drug** precertification, please use the RxBenefits, Inc. precertification request form.

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

TO	**Health Management Department**	**Fax (808) 535-8398** Phone (808) 791-7505 Toll-Free (888) 941-4622 ext. 302	
DATE			
FROM	Contact Person (If Other Than Physician)	Phone Number	Fax Number
	Requesting Physician's Name	EIN or SSN	
RE	Name of Patient	Patient's Sex ☐ Male ☐ Female	Patient's Date of Birth (mm/dd/yy) / /
	Name of Subscriber		Member ID Number

Diagnosis (ICD-10 Codes)	Description
Requested Services (CPT / HCPCS Codes)	**Description**

Anticipated Date(s) of Service	Anticipated Date of Surgery (If Applicable)	Anticipated Date of Admission (If Applicable)
Name of Facility Providing Service	Pertinent Clinical Information/Medical Justification for Requested Service	

Required documentation: To avoid any delays in this process, please provide supporting documentation along with your request including but not limited to medical history, physical examination results, diagnostic reports, and progress notes.

Outpatient rehab services and home health facilities: Please include a copy of the treatment plan (signed by the requesting physician) with this request form.

Our HM Department will notify you of the precertification decision after all information has been reviewed.

HWMG USE ONLY		
Authorized By	**Authorization Date**	**Precertification #**