Standard Register ® ZIPSET® F3 91733

[redacted]

HAWAII STATE MEDICAID (Title XIX) PROGRAM
P.O. BOX 1220, HONOLULU, HI 96807-1220

REFER TO INSTRUCTIONS ON REVERSE SIDE

A. TRANSPORTATION PROVIDER'S INVOICE NUMBER

AIR TRANSPORTATION REQUEST FOR PRIOR AUTHORIZATION AND TRANSPORTATION PROVIDER CLAIM FORM

1. IDENTIFICATION NUMBER	2. CATEGORY	3. SEC.	4. FM CODE	5. PATIENT'S FULL NAME	6. SEX MALE	FEMALE	7. BIRTHDATE Mo.	Day	Yr.	8. SERVICE DATES FROM Mo.	Day	TO Mo.	Day	Yr.

8. DATE I.D. CARD EXPIRES	9. UNIT	10. WORKER	C. TRANSPORTATION PROVIDER	D. PROVIDER NO. ✓ DIGIT	PRI. DIAG.	SEC. DIAG.
				—		

11. SUBSCRIBER OR CASE NAME AND ADDRESS	ADDRESS (IF NOT IN THE STATE OF HAWAII)	B1	B2	B3	B4	B5	B6
	CITY STATE ZIP CODE	B7	B8	B9	B10	B11	B12

12. EPSDT REFERRAL ☐ YES ☐ NO — COMPLETION REQUIRED

13. OTHER MEDICAL OR LIABILITY COVERAGE? ☐ YES ☐ NO
NAME OF CARRIER:

14. DATE OF ACCIDENT

15. IS THE ILLNESS OR INJURY:
WORK RELATED? YES ☐ NO ☐ THIRD PARTY? YES ☐ NO ☐
AUTOMOBILE? YES ☐ NO ☐ OTHER? YES ☐ NO ☐

16. REQUESTING PHYSICIAN PROVIDER NUMBER

E. STATEMENT OF SERVICES RENDERED	HCPCS CODE	MODIFIER CODE	F. CHARGES	NO OF VISITS	POS
DATE: ☐ ONE WAY	A0140				0
☐ ROUND TRIP	A0140				0
G. TAX	Z9020				
TOTAL CHARGES ▶					
H. LESS PAID BY PATIENT	Z9022				
I. OTHER MEDICAL COVERAGE	Z9014				

J. This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable Federal or State laws. I hereby agree to keep such records as are necessary to fully disclose the extent of services provided under the State's Title XIX plan and to furnish such information regarding any payments claimed above as the State agency may request.

TRANSPORTATION PROVIDER'S SIGNATURE _____ DATE ___/___/___

THIS SECTION TO BE COMPLETED BY ATTENDING PHYSICIAN

REQUEST IS BEING MADE FOR AIR TRANSPORTATION 17. FROM _____ CITY _____ 18. DATE OF TRAVEL _____

TO _____ 19. CITY: _____ 20. HOSPITAL: _____ 21. PHYSICIAN _____

22. EMERGENCY ☐ YES ☐ NO 23. TYPE OF TICKET ☐ ONE WAY ☐ ROUND TRIP 24. ATTENDANT NEEDED ☐ YES ☐ NO 25. TYPE TICKET ☐ ONE WAY ☐ ROUND TRIP

REFER PATIENT/ATTENDANT TO DHS CASEWORKER IF LODGING AND/OR FOOD IS REQUIRED.

26. DIAGNOSIS: _____

27. RECOMMENDED TREATMENT: _____

28. CHECK APPLICABLE BLOCKS:
PATIENT IS CONFINED TO A WHEELCHAIR ☐ YES ☐ NO STRETCHER ☐ YES ☐ NO
OXYGEN WILL BE REQUIRED IN FLIGHT ☐ YES ☐ NO OTHER LIFE SUPPORT ASSISTANCE MAY BE REQUIRED IN FLIGHT ☐ YES ☐ NO
URGENT MOVEMENT IS REQUIRED ☐ YES ☐ NO MOVEMENT BY AIR AMBULANCE IS REQUIRED ☐ YES ☐ NO

29. COMMENTS _____

MO. / DAY / YR

30. REQUESTING PHYSICIAN TYPED OR PRINTED NAME 31. PHYSICIAN SIGNATURE 32. DATE

NOTE: Approval of authorization is not a guarantee for payment. Provider must be certified by Medicaid, and the patient must be eligible for Medicaid benefits when services are rendered. Check patient's Medicaid I.D. card to verify eligibility status. Medical authorization expires 30 days from date of DHS Medical Consultant's signature.

THIS SECTION TO BE COMPLETED BY DHS MEDICAL CONSULTANT

MEDICAL AUTHORIZATION IS: 33. ☐ APPROVED 34. ☐ NOT APPROVED 35. ☐ DEFERRED FOR THE FOLLOWING:

36. PATIENT EMERGENCY ☐ YES ☐ NO 37. TYPE TICKET ☐ ONE WAY ☐ ROUND TRIP 38. ATTENDANT NEEDED ☐ YES ☐ NO 39. TYPE TICKET ☐ ONE WAY ☐ ROUND TRIP

40. COMMENTS: _____

41. DATE _____ 42. DHS MEDICAL CONSULTANT _____

NON-EMERGENCY: SEND ALL COPES TO DHS MEDICAL CONSULTANT, P.O. BOX 339, HONOLULU, HI 96809
EMERGENCY: SEND ORIGINAL ONLY TO DHS MEDICAL CONSULTANT
AIR AMBULANCE EMERGENCY: GIVE ALL COPIES TO AIR AMBULANCE CREW

FORM 208 (REV. 8/96) (06)

THIS COPY TO BE RETAINED BY DHS-HCAD