State of Hawaii
Department of Human Services
Med-QUEST Division

DHS/Med-QUEST Division
Clinical Standards Office
P. O. Box 700190
Kapolei, HI 96709-0190
Fax: 808-692-8131

REQUEST FOR PRIOR AUTHORIZATION OUT-OF-STATE MEDICAL TREATMENT

NOTE: INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS.

RECIPIENT INFORMATION

Recipient's Medicaid ID No.	Recipient's Name (Last, First, Middle)	Sex ☐ M ☐ F	Date of Birth (MM/DD/YYYY)

Medicare Coverage ☐ Yes ☐ No	Other Medical Insurance – Specify if primary or secondary
Attendant Requested ☐ Yes ☐ No	Medical Reason For Attendant / Name of Adult Attendant

Date(s) of Service	Procedures/Services	Procedure Code
1. ___/___/___ to ___/___/___		
2. ___/___/___ to ___/___/___		
3. ___/___/___ to ___/___/___		

Diagnosis

Reason For Out-Of-State Medical Treatment

REFERRING PROVIDER INFORMATION

Name of Referring Physician and Specialty	Referring Provider ID No.	Referring Provider Phone No.
Contact Person at Office	Phone No.	Fax No.
Referring Physician Signature Referring physician agrees to all follow-up care in Hawaii ☐ Yes ☐ No		Date

RENDERING PROVIDER INFORMATION

Name of Rendering Physician and Specialty	State Medicaid Provider ID No.	Rendering Provider Phone No.
Mailing Address		
City	State	Zip Code
Contact Person at Office	Phone No.	Fax No.

Does Rendering Physician agree to accept Medicaid Payment as Full Payment? ☐ *Yes* ☐ *No*

Services Provided In Hospital: ☐ Yes ☐ No If Yes, Name Of Hospital:

Contact Person at Hospital	Phone No.

THIS SECTION TO BE COMPLETED BY THE MED-QUEST DIVISION

Determination: ☐ Approved ☐ Not Approved ☐ Pended	Airfare: ☐ Yes ☐ No	Attendant: ☐ Yes ☐ No	Lodging: ☐ Yes ☐ No	Meals: ☐ Yes ☐ No	Taxi/Shuttle ☐ Yes ☐ No

Comments

DHS Medical Consultant Signature	Date

DHS 1144C (Rev. 10/08)