STATE OF HAWAII
Department of Human Services
Med-QUEST Division

ACS
P.O. BOX 2561
Honolulu, Hawaii 96804-2561

Page number _____ of _____

ACS USE ONLY
PA No.:_____

☐ **Urgent Request** ☐ **Extension Request** ☐ **New Request**

REQUEST FOR MEDICAL AUTHORIZATION

Check only ONE – Different Types of Services Must Be Requested on Separate 1144 Forms.

☐ BH – Psych. Testing/ & Detox	☐ HE- Home Health	☐ MD- Professional Services	☐ RE – Rehabilitation Services
☐ DM – Appl./DME/ Supplies	☐ LN – Sign Language Interpretation	☐ OP – Outpatient Facility	☐ SR – Hospice
☐ GT – Transportation	☐ LT – Long Term Care	☐ OS- Out of State Services	☐ SHOTT

****** This Form should NOT be used for: Incontinence Supplies, EPSDT Medically Fragile Services, Dental Services and Drugs. ******

NOTE: INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS. Approval of this request is not an authorization for payment or an approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of service being certified by Medicaid. The provider of service must verify patient eligibility at the time the service is rendered. Authorization expires 60 days from date of approval unless otherwise noted by the consultant.

PLEASE PRINT INFORMATION CLEARLY

Medicaid Identification Number:	Patient Name (Last, First, M.I.):	Gender [ ] M [ ] F	Date of Birth _____ / _____ / _____
Medicare Coverage? [ ] Yes [ ] No Is Patient receiving Medicare Home Health Benefits? [ ] Yes [ ] No	Currently at: [ ] Home [ ] SNF/ICF/ICF-MR Facility [ ] Other: _____ Patient Mailing Address (St., Apt. No., City, Zip Code) *name*		

Physician Section			**Supplier Section (Circle Rent or Repair)**			
Service Description	**Procedure Code**	**QTY**	**Purchase Price**	**Rent/ Repair**	**Period Requested From**	**To**
1						
2						
3						
4						
5						

Physician Section	**Physician/ Supplier Comments**
Diagnosis(es):	
Justification:	
Attachment: [ ] Yes [ ] No	If applicable: Serial No.: MSRP Attached: [ ] Yes [ ] No

I certify that the items and quantities above are prescribed by the physician indicated below and will be provided by the supplier.

Physician/Provider Signature: Date:

Print Physician/ Provider Name: Provider Number:

Print Contact Name: (if different from Physician) Telephone Number: Fax Number:

I certify that the items and quantities above are prescribed by the physician indicated above and will be provided by the supplier.

Supplier Signature: Date:

Print Supplier/ Company Name: Supplier Number:

Print Contact Name: Telephone Number: Fax Number:

To be completed by Medicaid (A= Approved P= Pended D= Denied R= Revoked)

Code Line	**Modifier(s)**	**QTY**	**Auth. Code**	**Approved Period From**	**To**	**Consultant Comments:**
1						
2						
3						
4						
5						