AFL HOTEL & RESTAURANT WORKERS H&W TRUST FUND

P.O. BOX 29939
HONOLULU, HI 96820
1-808-275-2520

Please fax all requests to: 808-275-2521

PRIOR AUTHORIZATION FORM

Referring Provider or Primary Care Physician: **Name:**	**TaxID#:**	**NPI#:**
Address of Referring Provider or Primary Care Physician:		
Name of Office Contact Person:	**Phone:**	**Fax:**
MEMBER/PATIENT INFORMATION		
Patient Name: **Relationship To Member (Self, Spouse, or Child):** **Member Name(if different from patient):**	**Patient Date of Birth:**	**Sex: _____F _____M**
MEMBER ID #:	**Primary Insurance:**	
Patient's Phone:	**Member Date of Birth (If different from Patient):**	
Address:		
Other Insurance (Third Party Liability, Workmen's Compensation):		
Date of Injury:		
TREATING SPECIALIST OR TREATING FACILITY INFORMATION		
Name of Treating Specialist or Facility:		
Address of Treating Specialist or Facility:		
Name of Office Contact Person:	**Phone: Fax:**	
Service(s) Requested:	**# of Units or Treatments Requested:**	**Requested Dates of Service:**
Diagnosis (Required):		**Inpatient Outpatient**
Required: ICD 10:	**CPT or HCPC Code:**	**DME Price:**

Prior authorization is based on the medical necessity of the services requested. Coverage is subject to eligibility and what your plan says at the time you get services. Payment of claims depends on the terms of your plan. How much is covered will depend on any coinsurance and maximums you may have. The approval of all or part of the services doesn't change any benefits listed in your benefits booklet. Your benefits booklet explains what your plan covers in more detail.