STATE OF HAWAII
Department of Human Services
Med-QUEST Division

ACS – Hawaii Sate Medicaid Fee for Service Program
Attn: DUR, P.O. Box 967
Henderson, NC 27536-0967

REQUEST FOR MEDICAL AUTHORIZATION

Check only One – Different Types of Services Must Be Requested on Separate 1144B Forms. [ ] Home Infusion PA [ ] Non-home infusion (Medication only) PA

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.

[1] Medicaid ID Number	[2] Recipient's Name (Last, First, M.I.)	[3] Gender [ ] M [ ] F	[4] Date of Birth / /
[5] Medicare Coverage? [ ] Yes [ ] No Is Patient receiving Medicare Home Health Benefits? [ ] Yes [ ] No	[6] Currently at: [ ] Home [ ] Hospital [ ] SNF/ICF/ICF-DD/ID Facility Recipient's Mailing Address (St., City, Zip Code)	[7] Expanded Early & Periodic Screening Diagnosis & Treatment (EPSDT): [ ] Yes [ ] No	

Physician Section			**Supplier Section (Circle Rent or Repair)**			
	[8] NDC Number or Drug Name, Strength, Units, Global Code, or HCPCS code	[9] QTY	[10] Purchase Price	[11] Rent/Repair	[12] Period Requested From:	To:
1						
2						
3						
4						
5						

Physician Section

[13] Diagnosis or ICD-9 code [14] BMI (for anorexiants):

[15] Period Requested [16] Prognosis

[17] Justification (include history of previous treatment) ([ ] Attachment)

[18] Print Prescriber's Name/Mailing Address	[19] Prescriber's Signature	
	[20] Prescriber's NPI	[21] Date
	[22] Telephone #	
	[23] Fax #	[24] Contact Name

Supplier Section

[25] Print Supplier's Name/Mailing Address			[26] Comments
[27] Contact Name	[28] Telephone #	[29] Fax #	
[30] Supplier's Signature	[31] Supplier's NPI	[32] Date	