PRIOR AUTHORIZATIONS

PROCESS

PA TEAM CONTACT INFO:

JOY MIYAT

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NOREEN IBANA

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1188 Bishop Street, Suite 1508

Honolulu, HI 96813

SERVICES

- ♥ **OHANA:** 1-888-866-4262
- ♥ **UNITED HEALTHCARE:** 1-888-980-8728
- ♥ **HMSA:** 1-808-948-6372
- ♥ **KAISER:** 1-808-432-5330
- ♥ **ALOHA CARE**: 1-808-973-0712

REQUESTING INCONTINENT SUPPLIES

DOCUMENTS REQUIRED:

- ♥ MD Order
- ♥ Clinical Justification/Progress Notes (must be current)

DELIVERY: Please contact VENDOR directly for delivery status (Contact Information is listed in CLIENT PROFILE). If you need further assistance, you may contact JOY or NOREEN.

MEDLINE CLIENTS: You must contact Medline directly every month to confirm supplies, otherwise supplies will NOT be delivered. **MEDLINE PHONE #:**

UHC: 1-877-816-5587 **OHANA:1-833-660-0905**

VA CLIENTS: You must contact VA directly for supplies and delivery information.

REQUESTING ENTERAL SUPPLIES

DOCUMENTS REQUIRED WHEN REQUESTING GLUCERNA/ ENSURE/ NEPRO/ BOOST:

- ♥ MD Order
- ♥ Clinical Justification/Progress Notes (must be current)
- ♥ Blood/Lab Test Results (Albumin level – must be current)
- ♥ Weight Records

DOCUMENTS REQUIRED WHEN REQUESTING THICKENER (THICK-IT):

- ♥ MD Order
- ♥ Clinical Justification/Progress Notes (must be current)
- ♥Swallowing Evaluation

DURABLE MEDICAL EQUIPMENT (DME)

DOCUMENTS REQUIRED WHEN REQUESTING:

- ♥ Detailed Prescription
- ♥ Medical necessity notes
- ♥ Certificate of Medical Necessity form (Completed & Signed)
- ♥ Clinical Justification/ Progress Notes
- ♥ Height & Weight.

IF DME NEEDS REPAIR/ADDITIONAL: Please contact the vendor directly.

REQUESTING FOR TRANSPORTATION

DOCUMENTS REQUIRED (GURNEY/ STRETCHER):

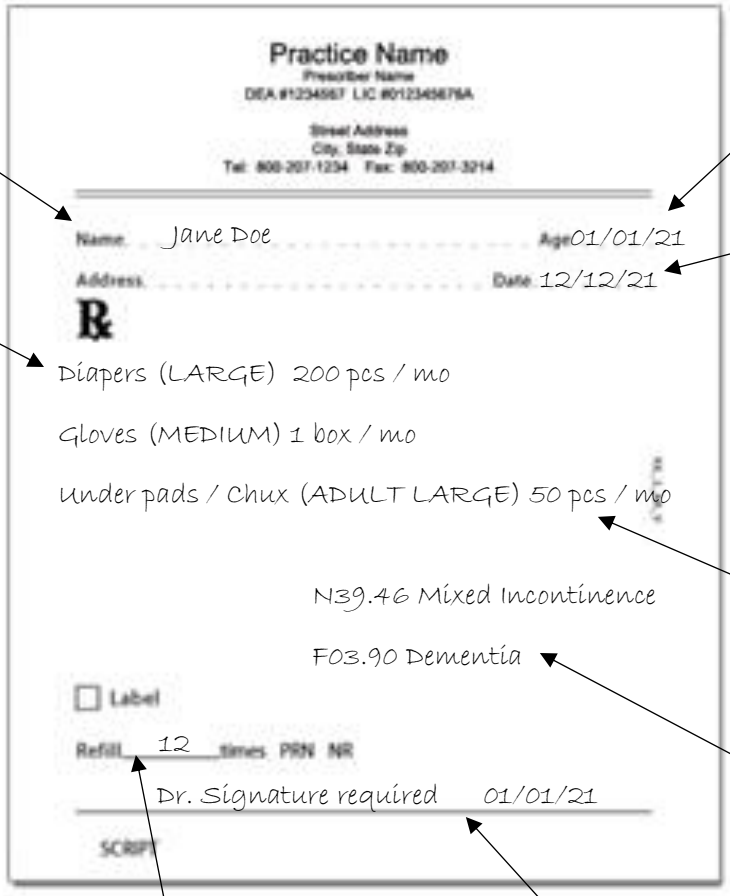
- ♥ Prescription/ Script
- ♥ Clinical notes.

DOCUMENTS REQUIRED (ON WHEELCHAIR):

- ♥ Must be using a non-collapsible wheelchair
- ♥ Need at least one-person assist
- ♥ Uses Hoyer lift (optional).

Caregiver to call for scheduling.
REQUEST ONLY IF APPLICABLE
Per HAR, it is the caregiver's responsibility to provide transportation for the client.

MD ORDER REQUIRED INFO



PATIENT NAME

DOB (DATE OF BIRTH)

DATE PRESCRIPTION WAS CREATED

ITEM(S)

<u>BE SPECIFIC</u> ON WHAT IS BEING REQUESTED:

- **INCONTINENCE** (EX: diapers, pull ups, gloves, underpads/chux). List the **SIZES** of all requested items
- **DME DURABLE MEDICAL EQUIPMENT** (EX: Wheelchair - *transport, manual, bariatric, pediatric??*, hospital bed – *electric, semi electric, half rail, full rail??*. Hoyer lift – accessories?). List all **ACCESSORIES** needed (EX: rails, elevated leg rests, cushions). **BE SPECIFIC!**
- **ENTERAL SUPPLIES** (SEE 1ST PAGE)

AMOUNTS

(HOW MANY PIECES OF EACH ITEM IS NEEDED?)

ICD 10 DIAGNOSIS CODE(S)

PCP SIGNATURE WITH DATE

REFILL AMOUNT; PLEASE DO NOT LEAVE THIS BLANK

ALONG WITH MD ORDER, PLEASE ATTCH CLINICAL JUSTIFICATION TO SUPPORT THE NEED FOR THE REQUESTED ITEMS. SEE 1ST PAGE FOR REFERENCE ON WHAT OTHER DOCUMENTS ARE REQUIRED FOR REQUEST