Authorization #_________________

Exp:_______________

Fax completed form to:

☐**Kaiser Moanalua (MOA) Specialty Dept for Referral INTO Kaiser**	☐ **Kaiser Authorization Dept for Out of Plan Referral**
Phone: (808) 432-8359 Fax: (808) 432-7380	Phone: (808) 432-5687 Fax: (808) 432-5691 Alt Fax: (808) 432-5667

** For STAT Care after hours or on weekends, call Kaiser MOA Operator (808) 432-0000 and have Specialist On-Call paged. If verbal authorization is obtained, submit this form the next Business Day.

REQUEST

(Select 1) ☐ Clinician Request ☐ Patient Request

(Select 1) ☐ Fax Clinical Notes with this Request ☐ EPIC EMR Notes in "Care Everywhere"

(Select 1) ☐ **Routine Care** ☐ **Urgent Episode Related Services**

MEMBER INFORMATION

Patient Name (Print):	Date of Birth	Kaiser Medical Record # **(Hawaii # only)**
Patient Home Phone:	Patient Mobile Phone:	

REFERRING TO

Specialty Department/Facility/Provider:

Diagnosis Code (ICD-10) and Description:

Services Requested (consult, procedure, treatment, imaging):

REFERRING FROM

Physician/Facility (Print):	Date:	Phone:	Fax:

Send Invoices / Bills to	**Kaiser Foundation Health Plan, Inc.** Hawaii Claims Administration P. O. Box 378021 Denver, CO 80237	**Phone Number: 1-877-875-3805**

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For Kaiser Permanente ARM Office Use only:

Authorization Comments:

Kaiser Specialty Department Use Only: ☐ Progress notes/reports faxed to referring practitioner
☐ Summary of Care document sent to referring practitioner

-THIS DOES NOT GUARANTEE PAYMENT. FOR INFORMATION ON THE EXTENT OF THIS PATIENT'S COVERAGE AND CURRENT-MEMBERSHIP STATUS, CONTACT CUSTOMER SERVICE AT 808-432-5955 (ON OAHU) OR 1-800-966-5955 (OUTER ISLANDS) Rev 03/04/2022