



**PHYSICIAN REQUEST FOR TRANSPORTATION, LODGING, AND MEALS
FAX TO: (866-790-8808)**

The following situations do **NOT** require authorization: 1. Off-island travel for appointments/procedures that do not require meals or lodging.
2. Adult attendant for minors.

Member Information

Name (Last, First, Middle):		Member Plan ID#:	
Street Address:		City:	Island:
Date of Birth:	Phone:	Preferred Transportation Provider:	

PCP Information

PCP Name:	Contact Name:	Phone:	Fax:
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Referring Medical Provider Information

Name (Last, First, Middle):		Provider ID#:	Today's Date:
Contact Name:		Phone:	Fax:

Appointment Information

Treatment/Description of Medical Service:			
Medical Reason for Treatment:			
Reason for Request (i.e., no specialist on island, procedure cannot be done on island, etc.):			
Rendering Provider ID#:		Rendering Provider Phone:	
Rendering Physician/Hospital:		Scheduled Date of Medical Service:	
Start Time (Date/Time Member Must Be Present):	Date:	Time:	
End Time (Date/Time of Release):	Date:	Time:	
Physical Address of Medical Service	Street:	City:	Island:

Travel Request Information

Departure Date:	Return Date:	Departure City/Airport:	Arrival City/Airport:
Medical Reason for Stay Longer If Than One Day:			
Type of Ticket: <input type="checkbox"/> One-way <input type="checkbox"/> Round-trip	Attendant Required? (If yes, will require additional 24 hours to process.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medical Reason for Attendant:		Name of Adult Attendant: (As Listed on Valid Photo ID)	
Lodging Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ground Transportation Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Member ADA Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Member Able to Ride Bus? <input type="checkbox"/> Yes <input type="checkbox"/> No
Meals Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Wheelchair Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	If own wheelchair, what type:	
Oxygen Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes: <input type="checkbox"/> Nasal <input type="checkbox"/> Mask	O2 Flow Rate:	
Other Special Travel Needs:			

This Section to be Completed by TMS or 'Ohana Health Plan

Ground Transportation Provider:		Authorization/Trip Number:
Air Transportation Provider:	Flight Information:	Authorization Number:
Lodging Provider:	Check-in Time (If applicable):	Authorization Number:
Meal Vouchers (Name of Restaurant):		Amount of Vouchers Approved: