STATE OF HAWAII
Department of Human Services
Med-QUEST Division

ACS – Hawaii Sate Medicaid Fee for Service Program
365 Northridge Rd, Suite 400
Atlanta, GA 30350

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 Patient'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-MR Facility Patient'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 Physician's Name/Mailing Address	19 Physician's Signature	
	20 DEA or Medicaid Provider #	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 NABP #	32 Date	

DHS 1144B (08/02)