



STATE OF HAWAII  
DEPARTMENT OF HUMAN SERVICES  
Med-QUEST Division  
Medical Standards Branch  
P. O. Box 700190  
Kapolei, Hawaii 96709-0190

**DO NOT USE. THIS FORM IS COMPLETED BY DHS/M&D.**

Notice of Approval of Inter-Island Air Transportation

This is to inform you that inter-island air transportation has been approved for:

Name and Mailing Address:	Medicaid ID#:
	Age:
	Phone Number:
	Alternate Number:
	Contact Person:

Worker Name: \_\_\_\_\_ Unit: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

Name of Companion: \_\_\_\_\_

Type of Ticket:  Round trip  Round trip with attendant  
 One way  One way with attendant

Departure Airport: \_\_\_\_\_

Wheelchair required:  Yes  No

Oxygen: Type: \_\_\_\_\_ Flow Rate: \_\_\_\_\_

Departure: Airline: \_\_\_\_\_ Flight#: \_\_\_\_\_ Time: \_\_\_\_\_ Ref. #: \_\_\_\_\_

Return: Airline: \_\_\_\_\_ Flight#: \_\_\_\_\_ Time: \_\_\_\_\_ Ref. #: \_\_\_\_\_

Comments: \_\_\_\_\_

**\*Please bring a picture identification and arrive at the airport 2 hours before your flight. CHANGES CANNOT BE MADE ONCE TICKETED.**

**\*If you require ground transportation, lodging, and/or food for overnight stay, please contact your DHS worker.  
\*Please notify your provider if you miss your appointment for ANY reason. If you travel Inter-Island and fail to show-up for your scheduled appointment without a valid reason, you have committed fraud and the Department will seek to recover your travel cost.**

**RECIPIENT INFORMATION**

1. Recipient's Medicaid ID No.		2. Recipient's Name (Last, First, Middle)		3. Sex <input type="checkbox"/> M <input type="checkbox"/> F		4. Date Of Birth (MM/DD/YYYY)	
5. Mailing Address							
6. City		7. State		8. Zip Code		9. Contact Person	
10. Day Time Phone Number							

**REFERRING PHYSICIAN INFORMATION**

11. Physician Name (Last, First, Middle)			12. Provider ID No.		13. Phone No.		14. Fax No.
15. Physician Signature				16. Contact Person At Office		17. Date	

**APPOINTMENT INFORMATION**

18. Diagnosis				19. Treatment/Description Of Medical Service			
20. Prior Authorization Required? <input type="checkbox"/> Yes <input type="checkbox"/> No			21. Prior Auth Apprvl No. (If Applicable)		22. Number Of Appointments Scheduled For This Trip: _____ (Provide Details For All Appointments Below)		
Appointment Details	23. Rendering Physician/Hospital		24. Rendering Provider ID No.		25. Rendering Provider Phone No.		
	26. Scheduled Date Of Medical Service		27. Start Time (Date/Time Recipient Must Be Present)		28. End Time (Date/Time Of Release)		
	29. Physical Address Of Medical Service						
Appointment Details	30. Rendering Physician/Hospital		31. Rendering Provider ID No.		32. Rendering Provider Phone No.		
	33. Scheduled Date Of Medical Service		34. Start Time (Date/Time Recipient Must Be Present)		35. End Time (Date/Time Of Release)		
	36. Physical Address Of Medical Service						
Appointment Details	37. Rendering Physician/Hospital		38. Rendering Provider ID No.		39. Rendering Provider Phone No.		
	40. Scheduled Date Of Medical Service		41. Start Time (Date/Time Recipient Must Be Present)		42. End Time (Date/Time Of Release)		
	43. Physical Address Of Medical Service						

**TRAVEL REQUEST INFORMATION**

44. Departure Date		45. Return Date		46. Medical Reason For Stay Longer Than 1 Day			
47. Departure City/Airport		48. Arrival City/Airport		49. Type Of Ticket (One-Way Or Round-Trip) <input type="checkbox"/> One Way <input type="checkbox"/> Round Trip			
50. Attendant Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	51. Name Of Adult Attendant (As Listed On Valid Picture ID)			52. Medical Reason For Attendant			
53. Oxygen Required? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, <input type="checkbox"/> Nasal or <input type="checkbox"/> Mask; O <sub>2</sub> Flow Rate _____			54. Wheelchair Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		55. Other Special Travel Needs		
56. Ground Transportation Required? <input type="checkbox"/> Yes <input type="checkbox"/> No			57. Lodging Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		58. Meals Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**THIS SECTION TO BE COMPLETED BY THE MED-QUEST DIVISION**

59. Determination: <input type="checkbox"/> Incomplete (See Comments) <input type="checkbox"/> One-Way <input type="checkbox"/> Round-Trip <input type="checkbox"/> No Air Transportation	Attendant/Companion: <input type="checkbox"/> Yes <input type="checkbox"/> No	Ground Transportation: <input type="checkbox"/> Yes <input type="checkbox"/> No	Lodging: <input type="checkbox"/> Yes <input type="checkbox"/> No	Meals: <input type="checkbox"/> Yes <input type="checkbox"/> No	Special Travel Needs: <input type="checkbox"/> Yes (see comments) <input type="checkbox"/> No	60. Tracking #	
61. Section/Unit #	62. Worker's Name			63. Worker's Phone		64. Worker's Fax	
65. Coupons Issued: <input type="checkbox"/> Yes <input type="checkbox"/> No		66. # Coupons	67. Coupon Serial Numbers		68. Name Of Airline		
69. Comments							
70. DHS Medical Consultant Signature							71. Date

Non-Emergent and Non-Urgent Conditions: If within 14 days fax to MSB-208 Processing (808) 692-8131. Otherwise fax or mail to Med-QUEST Division, MSB-208 Processing, P.O. Box 700190, Kapolei, HI 96709-0190

Emergency or Urgent Conditions: Fax to MSB-208 Processing (808) 692-8131

## INSTRUCTIONS

### DHS FORM 208 (Rev. 02/03) PRIOR AUTHORIZATION REQUEST FOR AIR TRANSPORTATION, LODGING, MEALS AND GROUND TRANSPORTATION

#### PURPOSE:

DHS Form 208 is used only when Fee-For-Service (NON QUEST) recipients need inter-island commercial air transportation. Inter-island medical travel is approved when medical services associated with the travel request cannot be obtained on the recipient's island of residence. Travel must be for medical reasons. Examples of medical reasons are treatments, consultations, surgery, follow up visits, hospital admissions and discharges.

#### REQUESTING PHYSICIAN:

- Check right hand corner box whether medical travel is Regular, Urgent or Emergency. **Emergency:** Medical conditions are those conditions that are manifested by ACUTE conditions of sufficient severity (including severe pains) such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman and/or unborn child) in serious jeopardy, or cause serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. **Urgent:** Medical conditions are conditions that require medical care within 2 business days. If the care is not received during this time, a person's life or health may be jeopardized.

Box 1-10: Complete all **RECIPIENT INFORMATION** section. You can obtain the information from the recipient's Medicaid identification card.

Box 11-17: Complete **REFERRING PHYSICIAN INFORMATION** section. Self explanatory.

Box 18-22: Complete **APPOINTMENT INFORMATION** section. List only agreed treatments, procedures, dates, appointments times with the rendering provider. Indicate the recipient's Diagnosis, Treatment/Description Of Medical Services. If information is available complete Prior Authorization Required. Provide the Number of Appointments Scheduled For This Trip.

Box 23-43: Complete and provide all Appointment Detail information.

Box 44-58: Complete **TRAVEL REQUEST INFORMATION** section. List accordingly to the needs of the recipient's temporary place of stay. Provide Departure Date, Return Date and Medical Reason For Stay Longer Than 1 Day. Indicate Departure City/Airport, Arrival City/Airport and Type Of Ticket. Indicate if Attendant Required, if "Yes", Name of Attendant and Medical Reason For



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October 18, 2002

MEMORANDUM

TO: Acute Care Hospitals and Nursing Facilities

FROM: Aileen Hiramatsu, Med-QUEST Division Administrator

SUBJECT: FOR IMMEDIATE RELEASE – FISCAL CHANGES IN THE 1147  
FORMS AND DELETION OF THE 1147b PROCESS

The utilization of the 1147b form will be discontinued effective November 1, 2002. The 1147 and 1147a will serve as both the level of care determination and a fiscal document component. In order for our new fiscal agent Affiliated Computer Services (ACS) to process the forms, minor revisions had to be made to the forms (attached).

Revisions and instructions to the 1147 initial/ongoing assessment form and the 1147a forms are as follows:

1147

- Changed DHS address to Mountain Pacific Quality Health Foundation's (MPQHF) address at top right corner of form;
- Deleted ICF/SNF in block number 10, E;
- Added Medicaid Provider Number in block number 9. Utilize your new Medicaid Provider Number;
- Added in Medicaid Provider Number, "Enter provider number for level of care on effective date";
- Deleted two of the Medicaid Provider Number lines in block number 12;
- Changed the Subacute Group to Subacute Level in block number 12; and
- Added Subacute Waitlisted in block number 12.

**1147a**

Changed DHS address to MPQHF's address at top right corner of form;

- Added Subacute Levels; and
- Added Subacute Waitlisted

**Instructions/Additional Information:**

- Facilities may continue to submit the 1147 forms for patients pending Medicaid eligibility, however; if the applicant becomes Medicaid Eligible and obtains a valid Medicaid Identification (ID) Number, an 1147a must be generated and approved by MPQHF in order for that facility to be paid;
- Contact your fiscal office to obtain your new provider number(s);

If a facility wants a level of care determination ONLY and will not bill for the services, it must submit the 1147 without a provider number;

- If there are any 1147b still outstanding, submit the new 1147a form to MPQHF in lieu of the 1147b effective November 1, 2002;

If in the event that your claim denies, resubmit a hard copy of the claim with the 1147 or 1147a with the effective approval dates that matches that claim;

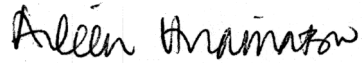
- Home and Community Based Programs and PACE do not need to enter their provider number, these programs have a different reimbursement process;
- There are only format changes with the 1147c form, continue the current process of the 1147c forms without the utilization of the 1147b form; and

MPQHF will forward all completed Subacute, Nursing Facility, Waitlisted 1147 and 1147a to our fiscal agent ACS *for payment that have a Facility/LTC Provider Number AND a Recipient Medicaid Number.*

In order for the claims to be properly processed, please remember that the 1147 and the 1147a will be linked to your facility's claim for reimbursement. Double check to ensure that you have the correct patient's name, Medicaid number, Medicaid provider number for the effective date of the level of care, level of care, and level of care approval period.

Discard the older version of the 1147 and 1147a and utilize the attached forms effective November 1, 2002. Mountain Pacific will not process any older 1147 forms effective November 1, 2002.

If you would like to obtain more forms via mail or email, call ACS Provider Inquiry Unit on Oahu at 952-5570 or Neighbor island can call toll free at 1-800-235-4378 or forms can be downloaded from the provider manual at [www.medquest.us](http://www.medquest.us). Should there be any questions, please call Ms. Kathleen Ishihara, Nurse Consultant at 692-8159.



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Med-QUEST Division Administrator

Attachments