HMSA

Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

Travel Assistance Request Form

The referring physician should fill out sections B & C

Please fax completed form to: (808) 944-5600
Or Mail to: HMSA / Medical Management Dept.
P. O. Box 2001
Honolulu, Hawaii 96805-2001
Phone No: (808) 948-6464 Oahu
(800) 344-6122 Neighbor Islands

- ☐ **HSTA**
- ☐ **Care Access Assistance Program**
- ☐ **Parent/Guardian for a minor**
- ☐ **Member to Book Flight**
- ☐ **HMSA to Book Flight**

REQUESTS SHOULD BE RECEIVED BEFORE THE APPOINTMENT DATE BUT NOT MORE THAN 5 DAYS AFTER THE APPOINTMENT.

CONTACT INFORMATION

Any questions or concerns regarding this request may be directed to:

Contact Name (First, Last) _____ Phone Number _____ Fax Number _____

A. MEMBER INFORMATION

Membership Number _____ Patient's Name (Last, First, MI) _____ Date of Birth _____

Companion's Name for Patients 17 yrs old or younger (Last, First, MI) _____ Companion is: ☐ Parent ☐ Legal Guardian ☐ Other, Please Specify _____

Day Time Phone _____ for Name (Last, First, MI) _____

B. ICD-9-CM/ICD-10-CM DIAGNOSIS CODE

Code(s): _____ _____ _____ _____

C. PROCEDURE/SERVICE/TREATMENT INFORMATION

CPT / HCPCS Code(s): _____ _____ _____ _____

Date of Appointment: _____ Time of Appointment: _____

D. PROVIDER INFORMATION

Requesting Provider Name (Last, First) _____ Provider ID _____

Address _____

Phone Number _____ Fax Number _____

Servicing Specialty Provider Name _____ Provider ID _____

Address _____

Phone Number _____ Fax Number _____

E. REASON FOR REFERRAL TO SPECIALIST PROVIDER

My patient cannot see an on-island specialist because: _____

IF TRAVEL ACCESS IS GRANTED, HMSA WILL INFORM THE MEMBER ONLY.