



Travel Assistance Request Form

The referring physician should fill out sections B & C



An Independent Licensee of the Blue Cross and Blue Shield Association

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

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

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

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 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.