Utilization Management
PO Box 3378 Honolulu, Hawaii 96801-3378
Phone: 453-6904, 453-6981 Fax: 453-6995

Service Authorization Request

Supportive Housing Increased units

All fields are **mandatory.** UM may send back requests that are inaccurate or missing fields. The provider may not add additional fields, categories or otherwise amend this form in any way. Requests for authorization must be submitted to UM within thirty (30) days of the provision of service.

Consumer Information

Name (Last Name, First Name, Middle Initial) :		
Date of Birth:	SSN:	Phone:

Insurance information

Health Plan:	United ☐	Ohana ☐	AlohaCare ☐	Kaiser ☐	Uninsured ☐	Policy #:

Agency Information

Name of Agency:	Provider Phone:
Submitted by:	Date of Submission:

Authorization Information

→ **Additional Units**	Authorization Number:
Service date(s):	Number of additional units:
Clinical Justification:	

Attestation *I attest that the service requested is clinically necessary for the above named consumer. I have reviewed and approved the information in the service authorization request*.

QMHP Name: (Please Print)	
License type:	Date Signed:
Signature:	