STATE OF HAWAII
Department of Human Services
Med-QUEST Division

ACS
P.O. Box 2561
Honolulu, Hawaii 96804-2561

REQUEST FOR MEDICAL AUTHORIZATION OF INCONTINENCE SUPPLIES

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. Do not submit for patients in SNF/ICF/ICF-MR facility as payment is included in the facility per diem.

PLEASE PRINT INFORMATION CLEARLY

Medicaid Identification Number:	**Patient's Name (Last, First, M.I.)**	**Date of Birth:**	**Gender:** [ ] F [ ] M

Present Address: [ ] Own Home/Family Home [ ] Care Home (CH) _____ [ ] Foster Home (FH) _____
(Name of CH) (Name of FH)
[ ] Medicaid Waiver Program [ ] Other _____

Patient's Mailing Address:
(Street, City and Zip Code)

TO BE COMPLETED BY PHYSICIAN. FAILURE TO COMPLETE NUMBERS 1 – 5 WILL RESULT IN RETURN OF REQUEST. SUBMIT JUSTIFICATION FROM PHYSICIAN FOR QUANTITIES EXCEEDING 200 DIAPERS, 50 UNDERPADS AND 100 GLOVES.

1) Incontinence is secondary to:
[List specific diagnosis(es)]

2) Recipient requires diapers:	3) Recipient requires underpads:	4) Caregiver requires gloves:	5) Required justification attached:
[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No
If Yes, number used per month _____.	If Yes, number used per month _____.	If Yes, number used per month _____.	If Yes, number of pages_____.
		Note: For Non-Latex Gloves submit medical justification.	

I certify that the above named patient is under my care and requires the number of incontinence supplies I have prescribed. Physician's Signature: _____ Date: _____

Physician/Provider Name:		Provider Number:
Contact Name: (If different from Physician)	Telephone Number:	Fax Number:

To be completed by Supplier.

Supplier Name:		Supplier Number:
Contact Name: (If different from Supplier))	Telephone Number:	Fax Number:
Supplier's Signature:		Date:

To be completed by Supplier.				**To be Completed by Medicaid (A=Approved P=Pended D=Denied)**				
Code	Item	Qty./Mo.	Period Requested	Qty./Mo.	Auth. #1	Auth. #2	Period Approved	Comments
T4521	Diapers, Adult Small/All Children's		From: To:				From: To:	
T4522	Diapers, Adult Medium/Large							
T4524	Diapers, Adult Extra Large							
T4541	Underpads, Large							
A4927	Gloves, Latex (each)							
A4927 -22	Gloves, Non-Latex (each)							

To be completed by Medicaid.

#1 Consultant/Reviewer Initial: Date:	Additional Comments:
#2 Consultant/Reviewer Initial: Date:	