IMAGING | THE QUEEN'S MEDICAL CENTER

The Queen's Medical Center–Punchbowl
The Queen's Medical Center–West Oʻahu
Outpatient Imaging Pre-Authorization Program
Phone: 808-691-4109
Fax: 808-691-8164
Email: imagingpreauth@queens.org

Provider Preference Form

PROVIDER CONTACT INFORMATION

Practice Name | Tax ID #

Provider Name (Last, First, Middle Initial) — National Provider ID

Provider Name (Last, First, Middle Initial) — National Provider ID

Provider Name (Last, First, Middle Initial) — National Provider ID

Street address, City, State, Zip Code — Office hours/Days of operation

Primary phone number | Primary fax number — Practice email address

Office manager name | Phone number — Email address

Outpatient scheduler name | Phone number — Email address

NOTIFICATION PREFERENCES

How would you like to be notified when authorization is obtained:

☐ Fax ☐ Phone ☐ Email: _____

☐ Notification not necessary ☐ Other:_____

You must be a State of Hawaiʻi licensed Physician, APRN or Physician Assistant to participate in the Outpatient Imaging Pre-Authorization Program.

Our representatives may contact your office to obtain more information if it is requested by the patients' health plan. Requested information includes, but is not limited to, clinical notes, information to support medical necessity, history and physical, insurance information, copies of insurance and ID cards, etc. This information will assist us with securing an authorization for the imaging study.

By signing below, you affirm that you are a participating provider with the Outpatient Imaging Pre-Authorization Program and will assist with any required information needed to enable the program to secure insurance authorization prior to services being rendered.

Signature — Date

PRINT EMAIL