HWMG
HAWAII-WESTERN MANAGEMENT GROUP, INC.

Interisland Access to Care Program

Providing Additional Access to Care for Members

We are pleased to offer this program to assist HMAA members and other plan participants with accessing specialty care from participating providers on another island when that care is not available on your home island.

How the Program Works

1. Your physician must:
   - Determine that the specialty care you need is not available from a participating provider on your island, and refer you to a participating specialist on another island.
   - Complete a Travel Request Form and send it to us prior to your appointment date.
2. Our Health Management Department will:
   - Review the request upon receipt of all pertinent information. We may approve travel for one appointment date at a time.
   - Let you know whether your request was approved and inform you of next steps.
3. If your request is approved, you must:
   - Make your travel arrangements. In certain cases, you may ask us for assistance.
   - After your appointment, mail or fax your receipts to our Health Management Department for reimbursement, along with a copy of your signed physician certification letter. Receipts must reflect your name, date of travel, and amount paid. Credit card statements are not accepted as receipts. You will be reimbursed up to a designated amount for each one-way segment.
4. If you need to schedule a follow-up appointment, you must submit another request.

Restrictions and Limitations

Interisland travel costs will not be covered if you are:

- Referred to a non-participating specialist.
- Referred for a service that is not a benefit of your health plan.
- Unwilling to see an available participating specialist on your home island.
- Unwilling to receive treatment via telehealth if it is an option.

In addition, you will not be reimbursed for:

- First-class or business class tickets, or multiple seats for the same passenger
- Companion airfare (for members aged 18 and older)
- Frequent flier miles or upgrades
- Ground or intraisland transportation (e.g., from Hilo to Kona)
- Reservation change fees or baggage fees
- Requests received after service is rendered
- More than six round trips for services requiring a daily course of treatment (e.g., radiation therapy or chemotherapy)
- More than ten round-trip tickets per calendar year
- Lodging, parking, meals, and any other travel costs

Reimbursement will be limited to the lowest-cost flight on the day of travel. If we book your travel and you do not keep your appointment, you must reimburse us for any costs incurred.

Questions

If you have any questions, please feel free to contact our Health Management Department at (808) 791-7505, toll-free at (888) 941-4622 x302, or CaseManagement@hwmg.org.

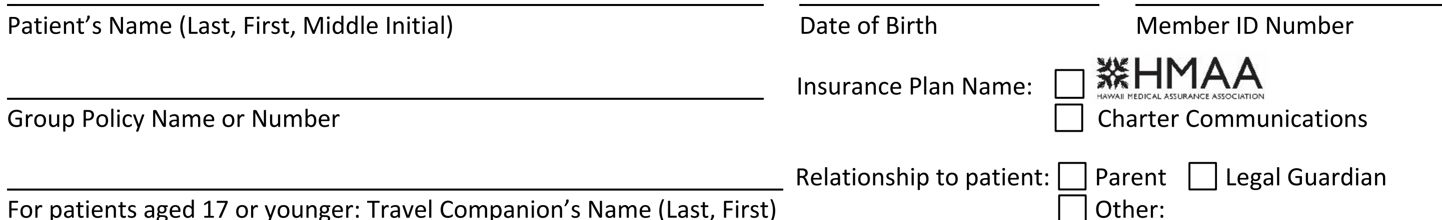
Interisland Travel Request

Please fax completed form to **(808) 535-8398**
Or mail to HWMG Health Management Department
737 Bishop Street, Suite 1200, Honolulu, HI 96813
Phone **(808) 791-7505**

Request must be received **before** the appointment date

Our Interisland Access to Care Program assists members and other plan participants with accessing specialty care from participating providers on another island by covering airfare when that care is not available on your home island. For members aged 17 or younger, travel may also be covered for an accompanying parent or authorized guardian. All requests are subject to eligibility, plan provisions, and retrospective review. Patients deemed ineligible for airfare reimbursement are solely responsible for the cost.

Part 1 - PATIENT TO COMPLETE



Patient's Name (Last, First, Middle Initial) ______________________ Date of Birth ______________ Member ID Number ______________

Group Policy Name or Number ______________________

Insurance Plan Name: ☐ HMAA (Hawaii Medical Assurance Association) ☐ Charter Communications

For patients aged 17 or younger: Travel Companion's Name (Last, First) ______________________

Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:______________

Questions regarding this request may be directed to: ______________________
Contact Person's Name (Last, First)

Phone Number ______________ Fax Number ______________ E-mail Address ______________

Part 2 – REFERRING PROVIDER TO COMPLETE

Referring Provider's Name (Last, First) ______________ Provider ID Number ______________ Phone Number ______________ Fax Number ______________

Practice Address (Including City and Zip Code) ______________________

Reason my patient cannot see an on-island specialist ______________________

I am referring my patient to:

Specialist's Name (Last, First) ______________ Date of Appointment ______________ Time of Appointment ______________

Practice Address (Including City and Zip Code) ______________ Phone Number ______________ Fax Number ______________

Requested Service(s): Diagnosis (ICD-10) Codes ______________ CPT/HCPCS Codes ______________

______________________ ______________
Referring Provider's Signature **Date**

Submit this form to our Health Management Department (contact information shown above) before the appointment date. After our review, we will notify the referring provider and member of our decision.