PMAG
Pacific Medical Administrative Group

FAX DIRECTLY TO IHH AT (808) 930-9874

Integrated Health Hawaii

CARE REFERRAL FORM

Provider Information

Provider Name		Date
Office Point of Contact	Phone Number	Fax Number

Patient Information

First Name	Last Name	Date of Birth (MM/DD/YYYY)
Phone Number / Mobile Number	Mailing Address	*POA: If applicable, also fax a copy of the Authorized Representative document.*

Primary Insurer: ☐HMSA PPO ☐HMSA HMO ☐HMSA Akamai Advantage
☐HMSA QUEST (ID#_____)

Non-HMSA: ☐Medicare FFS ☐AlohaCare ☐Ohana ☐UnitedHC
☐UHA ☐HMAA ☐Other: _____

Language Spoken In Household

Interpreter Needed: ☐Yes ☐No

SERVICE REQUESTED → *Patient notified AND agreeable to care management referral.

HMSA Only:
☐Complex Case Management ☐Disease Management
☐Health Coaching (☐Physical Activity /☐Nutrition /☐Tobacco Cessation/☐Stress Mgmt / ☐Other:_____)
☐Palliative Care / Supportive Care / Hospice

ALL Insurance Plans:
☐Behavioral/Mental Health Issues ☐Alcohol, Drug & Substance Use ☐Social Support
☐Geriatric Support/Caregiver Support ☐Transportation/ Housing/ Food Assistance

REQUIRED: PCP'S PRIMARY CONCERN (PLEASE INCLUDE PERTINENT MEDS AND PROGRESS NOTES)

PATIENT PLAN OF CARE (IHH Reports Sent Separately)

HMSA Care Manager / Health Coach Information

Name	Phone Number	Fax Number	Date	☐Initial ☐Follow-up

Problem(s) And Goal(s):

Patient Progress:

Action Taken:

Recommendation, Follow-Up, and Requests

Requesting Provider Response

(Provider's Response and Recommendation)

Notes: (1) Send further follow-up reports if there are significant changes **(2)** For more information and a more detailed report, contact the care manager/health coach.