Care Management Plan and Referral Form

Please fax the completed form to (808) 948-8242 or call the HMSA Intake Line (808) 440-7057.

Provider Information (Information to be completed by Provider)		
Name	Phone Number	Fax Number
Office Point of Contact:	PO Care Coordinator:	
Patient Information		
First Name	Last Name	Date Of Birth (MM/DD/YY)
Phone Number / Mobile Number	Mailing Address	Authorized Representative / Caregiver
Line of Business (LOB) ☐ HMSA Akamai Advantage ☐ HMSA PPO ☐ HMSA HMO ☐ HMSA Quest (ID#_____) ☐ Non-HMSA (Other Insurer):_____		Language Spoken In Household : _____ Interpreter Needed ☐ Yes ☐ No
Primary Care Provider's Concern		
Select Services Requested		
☐ Care Management ☐ Behavioral Health ☐ Certified Diabetes Education ☐ Health Coaching ☐ Complex Case Management ☐ Pregnancy and Postpartum Support ☐ Sexual and Gender Minority Navigation		

PATIENT PLAN OF CARE

Care Manager Information				
Name:	Phone Number:	Fax Number:	Date:	☐ Initial ☐ Follow-up
Problem/Goal:				
Patient Progress:				
Action Taken:				
Follow-up:				