OUT-OF-NETWORK REFERRAL REQUEST FORM
PACIFIC HEALTH CARE (PHC) | HMSA HMO

PART I & II REQUIRED | FAX TO (808) 943-8732 **Ref No:**

NOTE:
- Non-HMSA and out-of-state providers require an HMSA Administrative Review. PLEASE SUBMIT DIRECTLY TO HMSA FOR APPROVAL. Call HMSA at (808) 948-6464 for more information.
- Be aware of HMSA benefit caps on PT/OT services.
- Please pre-certify services and products with HMSA's current guidelines.
- Payment is subject to plan benefits and member eligibility at time of services

Part I Patient Information

★ REQUIRED FIELDS

☐ NON-URGENT ☐ URGENT (response needed within 3 business days) ☐ STAT (response needed within 24 hrs due to medical necessity)

Clinical reason for STAT (Scheduling not clinical reason) ▶

Date ★	Patient (Last Name, First Name) ★	Date of Birth ★	Insurance Number

Requesting PHC Provider (Last Name, First Name) ★	Patient's PCP (Last Name, First Name)

Signature ★ ▶ Note: Authorized signatures must a PMAG Provider or their staff

Contact Person ★ (Required if Staff signs for MD)	Phone Number	Fax Number ★

Reason for Referring Out-of-Network?

Note: Additional documentation may be required and requested. Insufficient information may delay processing of your referral.

Check the appropriate box ★

☐ Continuity of Care ☐ Patient Preference ☐ Patient Referred Self
☐ No PHC Provider Available ☐ No Other HMO Provider Available

Further Explanation Required ★ ▶

Part II Referring Patient To

Note: Non-HMSA and out-of-state providers require an HMSA Administrative Review.

Rendering Provider (Last Name, First Name) ★	Specialty / Specialties

Office Location ★	Phone Number

Start Date ★	End Date ★	Diagnosis (descriptions only) ★

Requested Services (check all that apply)

☐ Office Consultation ☐ Follow Up Visit (s) ☐ Hospital Visit(s) ☐ Rehabilitation ☐ Durable Medical Equipment
☐ Laboratory ☐ Pharmacy ☐ Injectables ☐ Sleep Study ☐ Other (specify) ▶

Referral Determination

To be filled by Partners for Quality Health, LLC

Disclaimer: Approval does not guarantee payment of claim

Medical Director's Signature ▶ Date ▶

☐ **APPROVED**
☐ One visit only.
☐ Please have patient establish within PHC Network:

☐ **NOT APPLICABLE**
☐ Not a PHC member.
☐ NO response to inquiry.
☐ In-network provider, referral not necessary.
☐ Requires an HMSA Administrative Review. Please contact HMSA Medical Management at (808) 948-6464.

☐ **NOT APPROVED**
☐ In-network provider available

Referral Management Notes ▶