PMAG
Pacific Medical Administrative Group
Services provided by PQH

BEHAVIORAL HEALTH ONLY: FAX DIRECTLY TO PQH AT (808) 943-8732
HMSA PATIENTS: FAX TO HMSA AT (808) 948-8242

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.***
HMSA Line of Business (LOB): ☐ Commercial ☐ QUEST (ID#________________) ☐ **Non-HMSA Insurer:** ☐ Medicare FFS ☐ Akamai Advantage **(Name:___________________)**		Language Spoken In Household Interpreter Needed: ☐ Yes ☐ No

Service Requested

☐ Complex Case Management ☐ Disease Management ☐ Patient notified about and agreeable to care management referral.

☐ Health Coaching (❍ Physical Activity / ❍ Nutrition / ❍ Tobacco Cessation/ ❍ Stress Mgmt / ❍ Other________________)

☐ **Behavioral Health offered for ALL INSURANCE PLANS. (Mental Health Issues)**

***REQUIRED: PRIMARY CARE PROVIDER'S PRIMARY CONCERN (PLEASE INCLUDE PERTINENT MEDS AND PROGRESS NOTES)**

PATIENT PLAN OF CARE

Care Manager / Health Coach Information

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

Problem(s) And Goal(s):

Patient Progress:

Action Taken:

Recommendation And Follow-Up

HMSA Clinician's Request And Recommendation:	☐ ***REQUESTING REFERRING 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.