PMAG
Pacific Medical Administrative Group

FAX DIRECTLY TO IHH (808) 930-9874

IHH 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:_____)

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.