

IHH Care Coordination REFERRAL FORM

Fax completed form to Integrated Health Hawaii (IHH) at **(808) 930-9874**

Provider Information		
Physician Name	Date	
Physician Specialty: <input type="checkbox"/> Adult <input type="checkbox"/> Pediatrician <input type="checkbox"/> Family		
Office Contact Person	Phone Number	Fax Number
Patient Demographic Information		
Patient Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> T
Primary Contact Name	Primary Contact Phone	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Relationship to Patient <input type="checkbox"/> Self/Patient <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Daughter/Son <input type="checkbox"/> Spouse <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Friend <input type="checkbox"/> Foster-parent <input type="checkbox"/> Other:		
Mailing Address (Street, City, State, Zip)		
Language(s) Spoken	Need Interpreter <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pacific Health Care (PHC) Subscriber Number:		
Referral Reasons		
<input type="checkbox"/> Medical: Coordination of care (specialist and other providers) <input type="checkbox"/> Behavior health: coordination for evaluation, dx, referral to mental health provider. <input type="checkbox"/> Developmental delay: referral to state agency (DOE, DDD) and other community resources. <input type="checkbox"/> Family: referral to family counseling, SDOH (housing, food, state/fed programs) <input type="checkbox"/> Geriatric/caregiver support: evaluation for referrals and services. <input type="checkbox"/> Social determinants of health: transportation, housing, food, state/fed programs.		
Addition Comments: <i>(Brief Description or Recommendations for referral)</i>		
Non – PHC		
HMSA Line of Business (LOB)	Non-HMSA Insurance	
<input type="checkbox"/> Commercial <input type="checkbox"/> QUEST <input type="checkbox"/> Medicare FFS <input type="checkbox"/> Akamai Advantage <input type="checkbox"/> HMO (Not PHC) <input type="checkbox"/> Other:	<input type="checkbox"/> UHA <input type="checkbox"/> Ohana <input type="checkbox"/> Tricare <input type="checkbox"/> UHC <input type="checkbox"/> AlohaCare <input type="checkbox"/> Other: <input type="checkbox"/> HMAA <input type="checkbox"/> Aetna	
Diagnosis or clinical presentation of: <i>(Required for Non-PHC patients 18+)</i>		
Provider's Request and Recommendation:	Provider's Signature	

NOTES: (1) Send follow-up reports if there are significant changes (2) For more information and detailed report, contact the IHH care coordinator.