

# Fax Transmission

Honolulu Pain Management Clinic, LLC  
500 Ala Moana Blvd, Suite 1-302 Honolulu, HI 96813  
Office: (808) 528-3657 Fax: (808) 524-6552

<b>TO:</b>	HONOLULU PAIN MANAGEMENT CLINIC, LLC	<b>DATE:</b>	
<b>FAX #:</b>	808-524-6552	<b>PAGES:</b>	2 (INCLUDING THIS COVER)
<b>PHONE #:</b>	808-528-3657		
<b>FROM:</b>			
<b>SUBJECT:</b>	NEW PATIENT REFERRAL		

**COMMENTS:** \*MVA/No-Fault, Aloha Care/QUEST. Medicaid/Ohana/Evercare (QExa) patients not accepted.

Aloha -

Thank you for your recent referral. All patients are contacted within two business days after receipt of referral.

**Please complete the attached form and also include:**

- Recent case notes along with patient diagnosis
- Operative Reports from last injection procedure
- RADIOLOGIST Reports (Xray / MRI)
- WRITTEN Prior Authorizations (for Work Comp, HMO or out of network referrals)
  - Treatment requested should be for pain management consultation
- Work Compensation:
  - Patient must have primary/attending physician in place, as we do not take over as attending/primary MD on WC claims.
  - The Honolulu Pain Management Clinic, LLC will call the patient to schedule their initial consult within two business days after the receipt of written authorization from the adjuster/insurance carrier.

Thank you.

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivery of the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited by law.

If you have received this communication in error, please notify us immediately by telephone, and return the original materials to us at the above address via US Postal Service. Thank you.

Instructions to the authorized receiver: Please review the documents received for appropriate legibility and number of copies, and if not satisfactory, please advise the sender immediately.

# HONOLULU PAIN MANAGEMENT CLINIC, LLC

500 ALA MOANA BLVD, SUITE 1-302 ♦ HONOLULU, HI 96813 ♦ Ph: (808)528-3657 ♦ FX: (808) 524-6552

*Please fax Referral Form with pertinent medical records to (808) 524-6552.*

INITIAL CONSULT REFERRAL BY: \_\_\_\_\_

DATE: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

NPI#: \_\_\_\_\_

CONTACT NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

DOB: \_\_\_\_\_

SSN#: \_\_\_\_\_

EMER. CONTACT: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

**INSURANCE: PLEASE NOTE:** We do NOT accept MVA/No-Fault, Aloha Care/QUEST, Medicaid/Ohana/Evercare (QExa)

Medicare  Medicaid  HMSA PPO  HMSA Akamai Advtg  HMO\* \_\_\_\_\_  BCBS  UHA

Tricare\*  VA\*  VA Triwest\*  HMA  HMAA  Ohana Medicare  Other \_\_\_\_\_

Workers Comp.\* DOI: \_\_\_\_\_ Ins. Co. \_\_\_\_\_ Claim#: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Case Mgr: \_\_\_\_\_ Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

**\*REQUIRES PRIOR AUTHORIZATION FOR CONSULT**

NOTES: \_\_\_\_\_

Please Submit referral request with the following:

- Recent medical records (w/ MD Referral)
- Xray/MRI Reports (if available)
- Current Medication List
- WC/HMO Authorization
- Copy of Insurance Card

Office Use Only: Appt Date: \_\_\_\_\_ Check in: \_\_\_\_\_

Mailed Forms: \_\_\_\_\_