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

TO:	HONOLULU PAIN MANAGEMENT CLINIC, LLC	**DATE:**	
FAX #: **PHONE #:**	808-524-6552 808-528-3657	**PAGES:**	2 (INCLUDING THIS COVER)
FROM:			
SUBJECT:	**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.

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 NOTE 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: _____