AlohaCare QUEST Integration Service Coordination Referral Form

REFERRAL INFORMATION:

Referred by _____ Phone Number _____ Fax Number _____

Relationship to Member _____

MEMBER INFORMATION:

Medicaid/QUEST Integration ID# _____ Member's Name (Last, First, MI) _____ Date of Birth _____

Phone _____ Address (Street, Cty, State, ZIP) _____

Member's Authorized Representative/Guardian/Caregiver _____

PROVIDER INFORMATION:

PCP/Specialist Name _____ Phone Number _____ Fax Number _____

REASON FOR REFERRAL:

☐ Medical Needs ☐ Behavioral Needs ☐ Advance Care Planning ☐ Other: _____

Diagnosis Code(s): _____

Please fax completed form to: (808) 973-7374
Or Call (808) 973-0712

For AlohaCare use:
Date Received: _____
Referred to: ☐ LTSS ☐ SHCN

Last updated 04/2017