



New Member Transition of Care Form EUTF

Please assist us in making the transition into our health plan as smooth as possible. If this applies to you or any of your dependents under your plan, please complete and return to us. If you need clarification, please call Health Services at (808) 954-8796 or toll free at 1(866) 826-5335. Mahalo !

PART 1			
Name: _____		ID# (if known): _____	
Last	First	Middle Initial	
Address: _____		City: _____	Island: _____ Zip: _____
Street	Apt#		
Phone: _____	Date of Birth: ____/____/____	Male <input type="checkbox"/>	Female <input type="checkbox"/>
	Month Day Year		
PART 2			
Please place an "x" next to any of the following medical conditions that you are currently receiving treatment. Write additional medical problems in the blank spaces.			
X		X	
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	
<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	
<input type="checkbox"/>	Hemodialysis	<input type="checkbox"/>	
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	
<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	
<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	
<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	
<input type="checkbox"/>	Lupus	<input type="checkbox"/>	
PART 3			
For women: Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes, I am _____ months pregnant			
Any anticipated problems with delivery / baby? <input type="checkbox"/> No <input type="checkbox"/> Yes			
PART 4			
Do you have any planned surgical procedures or hospital admissions? <input type="checkbox"/> No <input type="checkbox"/> Yes – Please provide date and nature of procedure/admission as these may require a prior authorization.			
Does your doctor prescribe any self injectable medications for you? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list:			
Any other pertinent health information ?			

Print member name: _____ Member signature _____

Protected Health Information (PHI) will not be disclosed to other parties without your written authorization, except those directly involved in your care or as required by law.

When form is completed please return by fax or mail to:

HMA, INC. / c/o Health Services
Pacific Guardian Tower – Suite 1020
1440 Kapiolani Boulevard
Honolulu, Hawaii 96814
Fax: 1 (866) 206-5655