HMSA QUEST Integration
Referral Form

An Independent Licensee of the Blue Cross and Blue Shield Association

Please fax completed form to 948-5648 (Oahu) or 1 (800) 960-4672 (Neighbor Islands). For questions, call 948-6486 or 1 (800) 440-0640 toll-free.

MEMBER INFORMATION

MEMBERSHIP NO.:	PATIENT NAME: Last Name, First, MI
DATE OF BIRTH:	PHONE:

REFERRING PROVIDER INFORMATION

PRIMARY CARE PROVIDER: Last Name, First Name, MI	PROVIDER NO:
PHONE:	
PATIENT BEING REFERRED TO: Last Name, First Name, MI	PROVIDER NO:
PHONE:	

MEDICAL/SERVICE INFORMATION

DIAGNOSIS REQUIRING REFERRAL
ICD10-CM Code: Description:

SERVICE DATE(S) FROM: TO:

CHECK HERE IF REFERRAL IS FOR EPSDT FOLLOW-UP OR RELATED SERVICES: ❑

ENABLING SERVICES FOR QUEST INTEGRATION MEMBERS ONLY

Attendant request for members 18 years old and over must be accompanied with a medical note supporting the reason for the attendant. An attendant is someone who's needed to physically assist a member to/from an appointment during the course of their travel. Travel requests must be received five business days prior to the date of travel. Incomplete travel requests will be denied.

APPOINTMENT DATE:	APPT TIME:	Total hours for APPT:
APPOINTMENT ADDRESS:		

AIR	Date:	❑ One-way ❑ Round-trip	**GROUND**	Date:	❑ One-way ❑ Round-trip
	From: To:			From: To:	
	Comments:			Comments:	
LODGING	DATE From: To:			ATTENDANT: DOB: RELATION:	
	Comments:			Reason for Attendant:	

COMMENTS: