HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION
737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813
Phone (808) 791-7505 / Toll-Free (888) 941-4622 ext. 302

New Member Continuity of Care Notification Form

To help ensure your continuity of care, please assist us in making your transition to our health plan as smooth as possible. If the below applies to you or any of your dependent(s) who will be covered under your Plan, please complete and return this form to us via mail or fax. Attach additional sheets if needed. Thank you for your cooperation.

Date		737 Bishop Street, Suite 1200 Honolulu, Hawaii 96813 Fax: (808) 535-8398	
To	HMAA Health Management Department		
From	Contact Person (If Other than Member)	Phone Number	Fax Number
	Name of Company Enrolled with HMAA		
Re	Name of Member (last, first, middle initial)	Member ID Number (if known)	Member's Date of Birth (mm/dd/yy) / /

Section 1: Current Health Conditions

Complete this section if you are currently receiving care or have been advised by a physician or other practitioner to receive healthcare services or medication. Use an "X" to mark all the conditions that apply. For all conditions that you mark with an "X", provide details in Section 2 below.

- ☐ Cancer or Tumor
- ☐ Dialysis
- ☐ Pregnancy; due date: _____
- ☐ Counseling or Therapy
- ☐ Fertility Treatment
- ☐ Transplant
- ☐ Diabetes or Endocrine
- ☐ Medication or Medical Equipment for Long-Term Use
- ☐ Other Condition(s) Not Listed Above: _____

Section 2: Planned Surgeries or Procedures

Complete this section if you have any planned surgeries or procedures, as these may require precertification by our Health Management Department or delegated precertification reviewer.

Date of Procedure	Type of Surgery or Procedure	Nature of Procedure or Notes	Physician Name and Phone Number

Section 3: Medication or Medical Equipment

Complete this section if you are using any medication or durable medical equipment (DME), as these may require precertification by our Health Management Department or delegated precertification reviewer.

Date Prescribed	Type of DME or Medication Name, Dosage, and Frequency	Description of Condition(s) Being Treated	Prescriber Name and Phone Number

HMAA USE ONLY	
Reviewed by	Date