HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

New Member Continuity of Care

Welcome to HMAA! We are pleased to have you as a new member and want to ensure your transition is as smooth as possible.

If you or any of your dependents covered under your health plan are undergoing treatment, have surgeries or procedures scheduled, are taking medication, or are renting medical equipment, this document will help reduce disruptions as you transition to HMAA.

Planned Surgeries or Procedures

Some medical services require prior approval (precertification) to ensure medical necessity and appropriateness. These services are described in HMAA's Precertification List *(hmaa.com > Members > Forms & Info > Plan Benefits and Information > Precertification List)*.

If you or your covered dependents have planned or are planning to have any service that requires precertification:

- List these in **Section 2** of the New Member Continuity of Care Form.
- Attach a copy of the approval letter from your previous health plan.
- If you have not received approval for your surgery or procedure, please ask your doctor to complete a precertification request form *(hmaa.com > Providers > Forms & Info > Precertification and Access to Care)* and send it to our office as soon as possible.

Medication

HMAA's Prescription Plan Formulary specifies drugs that are covered, not covered, require prior approval, or typically available at a lower copayment *(hmaa.com > Members > Forms & Info > Plan Benefits and Information > Prescription Plan Information).* Review the list carefully, and note it is not all-inclusive and is subject to change.

Medication that requires prior approval is described in the **Drugs** section of HMAA's Precertification List. If you or any of your covered dependents are taking medications that require prior approval:

- List these in **Section 3** of the New Member Continuity of Care Form
- Attach a copy of the approval letter from your previous health plan.
- If you have not received approval for your medication, please ask your doctor to complete a medication prior authorization request form *(hmaa.com > Providers > Forms & Info > Precertification and Access to Care)* and send it to our office as soon as possible.

Medical Equipment

If you or any of your covered dependents are currently renting medical equipment:

- List these in **Section 3** of the New Member Continuity of Care Form
- Attach a copy of the approval letter from your previous health plan.
- If you have not received an approval for your equipment, please ask your doctor to complete a precertification request form *(hmaa.com > Providers > Forms & Info > Precertification and Access to Care)* and send it to our office as soon as possible.

Failure to provide this information to HMAA may result in delayed payment or denial of your claims.

If you have questions, please contact our Health Management Department at **(808) 791-7505**, toll-free at **(800) 621-6998 ext. 302**, or HM@hmaa.com. Thank you for your cooperation.

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION
220 S KING STREET, SUITE 1200
HONOLULU, HAWAII 96813

New Member Continuity of Care Form

Please assist us in making your transition to our health plan as smooth as possible by helping to ensure your continuity of care. If the below applies to you or any of your dependent(s) who will be covered under your health plan, please complete and return this form along with any precertifications or approvals you received from your previous health plan.

HMAA Health Management Department, 220 S. King St, Ste 1200, Honolulu, HI 96813
Fax (808) 535-8398 | Email HM@hmaa.com

Attach additional sheets if needed. Contact us at **(808) 791-7505** or toll-free at **(800) 621-6998 ext. 302** if you have questions. Thank you for your cooperation.

Member's Name (Last, First, Middle Initial) _____ Date of Birth _____ Member ID (if known) _____

Name of Company Enrolling with HMAA _____ HMAA Effective Date _____ Today's Date _____

Questions regarding this form may be directed to: _____
Contact Person's Name _____ Relationship to Member _____

Phone Number _____ Email Address _____

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. Please mark all the conditions that apply. For all conditions that you mark, 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 reviewer.

Date of Procedure	Type of Surgery or Procedure	Nature of Procedure or Notes	Physician Full Name	Physician Phone #

Section 3: Medication or Medical Equipment

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

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

Completed by (Member or Member's Representative Signature):	Received by (HMAA):	Reviewed by (HMAA):
Date:	Date:	Date: