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

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, fax or email to:

HMAA Health Management Department, 220 South King Street, Suite 1200, Honolulu, Hawaii 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 _____ Today's Date _____

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

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 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