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: ❑	
Submitted by:	Phone:
COMMENTS:	