Print Form

700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4006
F 866.572.4384
www.uhahealth.com

Transition Coverage Questionnaire

Personal & Confidential

Company Name: _____

Welcome to UHA! The information you provide by completing this form will be used to assure the continuity of medical services during your transition from your previous carrier to UHA, for yourself, as well as your covered dependents. Because some services and medications require prior authorization, answering the following questions will allow us to better assist you.

1) Are you or a covered dependent scheduled for or anticipating surgery? ☐ Yes ☐ No

2) Are you or a covered dependent currently using any Durable Medical Equipment (DME)? ☐ Yes ☐ No

(e.g. wheel chair, hospital bed, CPAP machine, nebulizer, oxygen equipment, injectables other than insulin such as fluids, nutrition, or medications by infusion)

3) Are you or a covered dependent taking medications that may require special arrangements? ☐ Yes ☐ No

4) Are you or a covered dependent receiving care or anticipating care outside the state of Hawaii? ☐ Yes ☐ No

5) Do you or a covered dependent have any special medical needs that you would like for us to be aware of? ☐ Yes ☐ No

If the answer to ANY of the above questions is "Yes," for you or your covered dependents, please complete the rest of this form. (One form per person)

NOTE: Completion of this form does not guarantee coverage of services.
Coverage is subject to plan benefits and member eligibility at the time of service.

Instructions:

1. Return the completed form to the UHA Health Care Services Department via fax at 866-572-4384, or mail to:
   Health Care Services
   UHA
   700 Bishop Street, Suite 300
   Honolulu, HI 96813
2. Send a copy to your primary care doctor (PCP)
3. If you need more help, call a UHA Health Care nurse at 532-4006 or 800-458-4600, extension 300

Do not send this form to your Human Resources office.

A UHA Representative may call you to discuss the transition of your care.

Member/Patient Information (Please print)				
Member Name:				Member #:
	Last	First	M.I.	Birth Date:
Address:				Tel. Number:
Member or Legal Guardian Signature: (for under 18)				
Your Primary Physician				
Physician Name:				Tel. Number:

MEDICAL HISTORY

Please complete this section for the member listed above as applicable; use the next page if needed.

Current hospitalization or scheduled admission to a hospital for a procedure or test		
Date Scheduled / Admitted	Reason or Diagnosis	Hospital and Physician

Please complete this section, as applicable, if you are currently on dialysis, plan to start dialysis, or received a kidney transplant		
Dialysis start date:	Dialysis type (hemodialysis or peritoneal):	Facility:
Transplant date:		
Medicare Part A effective date (attach copy of Medicare card):		
Medicare Part B effective date (attach copy of Medicare card):		

List current use of Durable Medical Equipment (DME) and supplies (i.e., wheel chair, hospital bed, CPAP machine, oxygen equipment, fluids, nutrition, tube feedings)			
Start Date	Description	Vendor	Purchase or Rental

List all prescription medication(s) currently taking (include all oral, inhaler, injectable, topical)			
Name of Drug	Generic or Brand?	Strength	Frequency Taken

Certain medications and services require prior authorization

You may obtain a list of services and medications that require prior authorization on our website at www.uhahealth.com

NOTES: You may use this area for additional space or to record other special needs. You can also use this section to communicate to UHA any information to facilitate & expedite the transition of your care.