HPV Education for Providers and Families

Research indicates that clinician recommendation is the number one reason parents decide to vaccinate. This is especially important for the HPV vaccination. CDC now recommends that 11 or 12 year olds receive 2 doses of HPV vaccine instead of 3. This resource helps explain the reasons for changing the HPV vaccine recommendation, and provides tips for talking with the parents of your patients about the change. https://www.cdc.gov/hpv/hcp/for-hcp-tipsheet-hpv.pdf

Recommend same-day HPV vaccination, in the same way you recommend all other vaccines for patients age 11 or 12 years. It turns out that less is more: a recent *Pediatrics* study found that when doctors made brief statements that presumed parents intended to vaccinate their child, vaccine rates increased by 5 percent. http://www.npr.org/sections/health-shots/2016/12/05/504136418/when-doctors-talk-to-parents-about-hpv-vaccine-make-it-brief

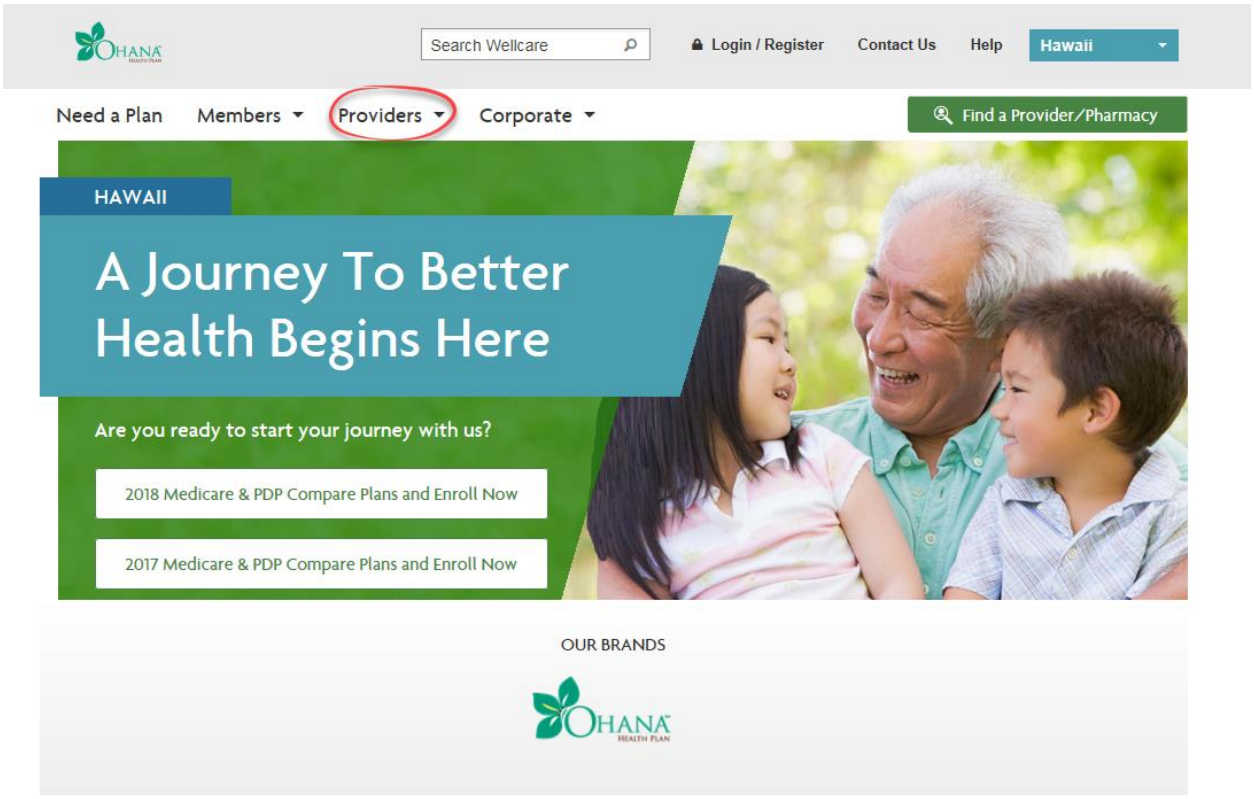
Get more tips on talking to parents. https://www.cdc.gov/hpv/downloads/hcvg15-ptt-hpv-2dose.pdf

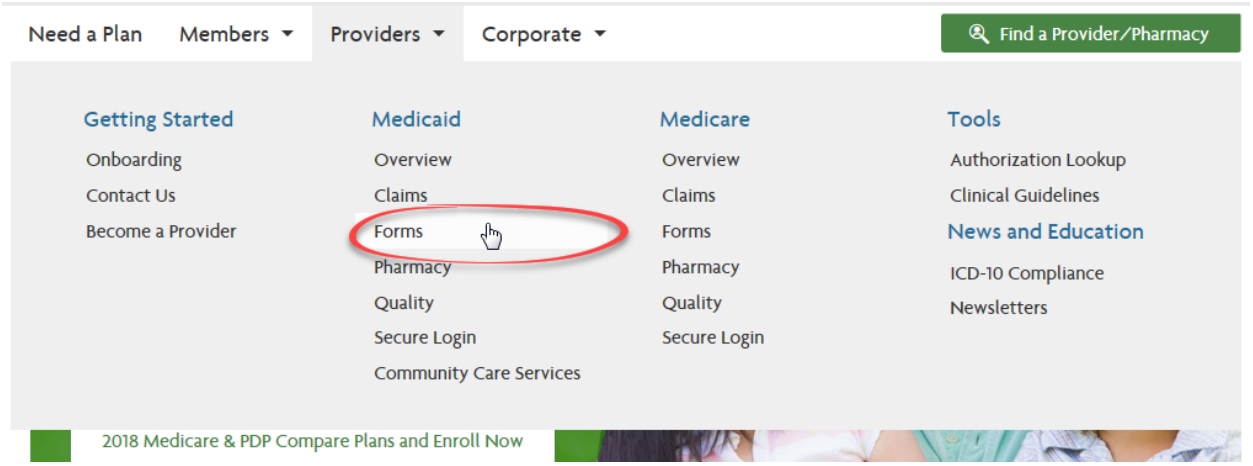
Establish a policy to reduce missed vaccination opportunities. Create a system to check immunization status ahead of all sick and well visits. Before seeing the patient, staff should indicate if the patient is due for immunization, with special consideration to the HPV vaccination. Take a few minutes to read AAP's HPV Toolkit, section on "Making a Change in Your Office". https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/HPV-Champion-Toolkit.aspx

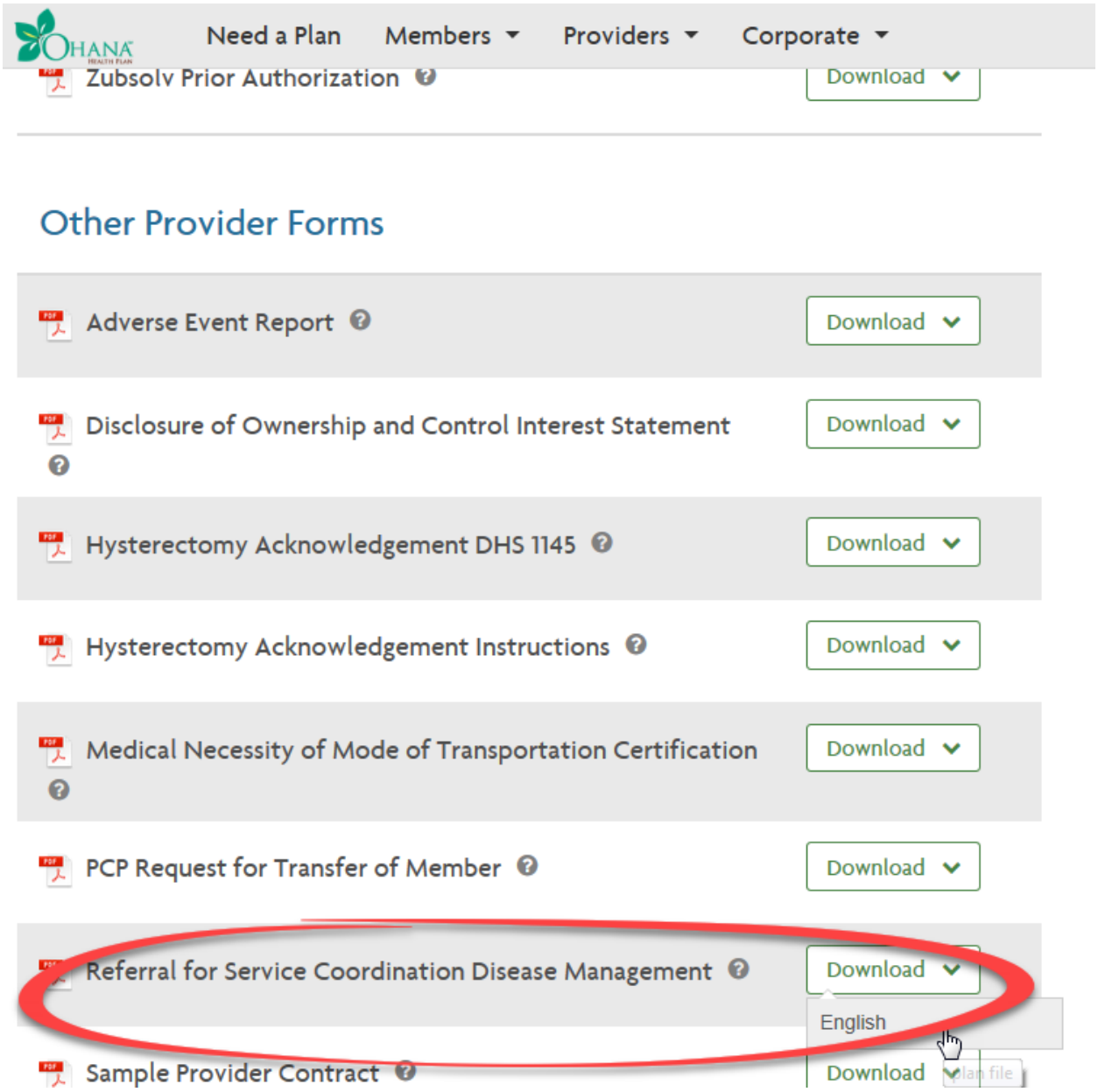
‘Ohana Health Plan Forms

Service Coordination Referral

www.wellcare.com/hawaii






Need a Plan
Members
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Corporate
Zubsolv Prior Authorization
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Other Provider Forms
Adverse Event Report
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Disclosure of Ownership and Control Interest Statement
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Hysterectomy Acknowledgement DHS 1145
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Hysterectomy Acknowledgement Instructions
Download
Medical Necessity of Mode of Transportation Certification
Download
PCP Request for Transfer of Member
Download
Referral for Service Coordination Disease Management
Download
English
Sample Provider Contract
Download

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Kapolei, HI 96707

Health Services Referral Form

Please use this form to refer a member to the
Service Coordination / Disease Management Department

Fax to 1-855-703-8078 or Call Customer Service @ 1-888-846-4262

Member Information		
Name:	Phone #:	DOB:
'Ohana Member ID #:	Other Health Insurance & ID #:	
Caregiver / Contact Person:	Phone #:	

Referring Source Information		
Name of Referring Source:	Today's Date:	
Contact Name:	Phone #:	Fax #:

☐ Physician's Office ☐ Public Health Nurse ☐ Nurse Advice Line ☐ Member's Family/Caregiver
☐ Member ☐ Care Manager (Agency) _____ ☐ Other _____

Reason for Referral

☐ Member needs assistance with medication compliance & adherence to medical treatment plan
☐ Member needs coordination of services
☐ Member needs screening for home-based services
☐ Member needs assistance accessing Behavioral Health services
☐ Member inquiring about foster home or long-term care placement
☐ Member needs health education in: ☐ Asthma ☐ Diabetes ☐ CAD ☐ Depression
☐ Other _____

Clinical Information / Other Information: *Include supporting clinical records, if necessary*

Other Pertinent Information

☐ Primary Diagnosis :
☐ Behavioral/Psychosocial barriers:
☐ Cognitive/ Physical deficits:
☐ Communication barriers:

Completed by 'Ohana Staff

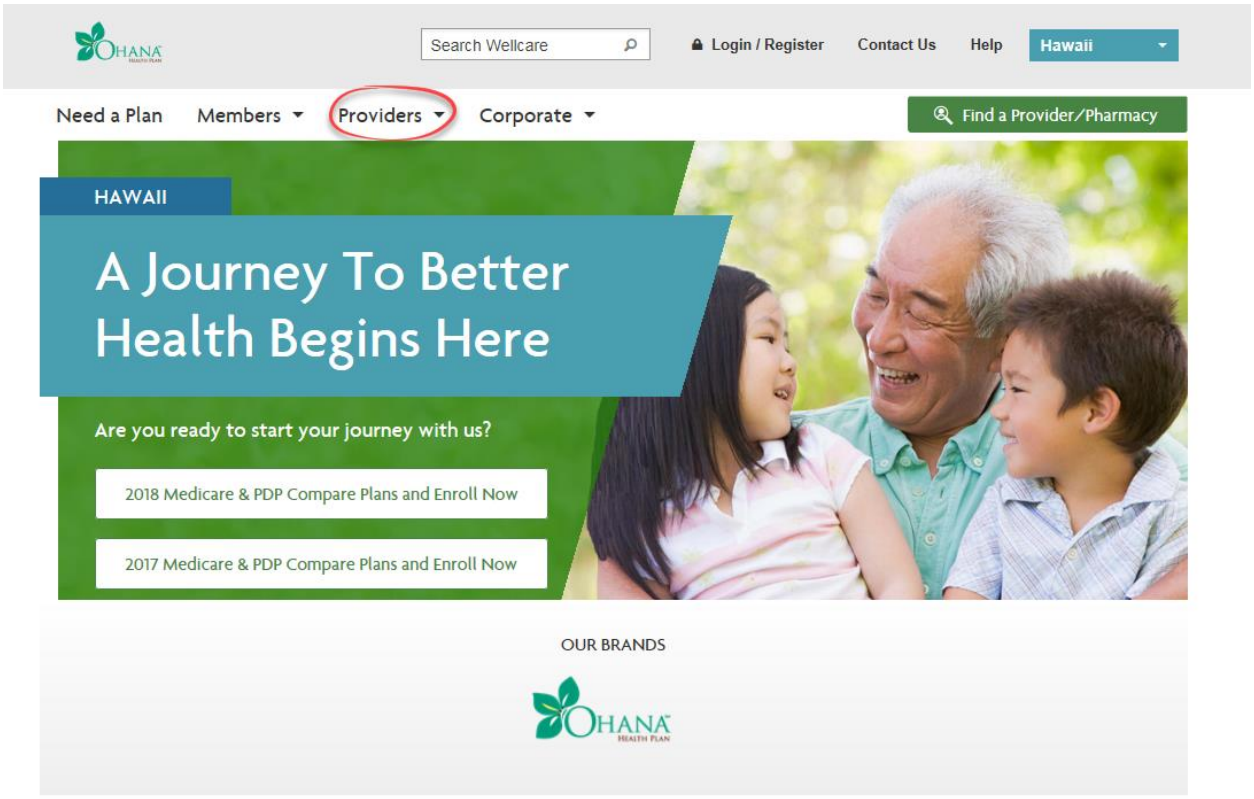
Referred to: ☐ SC _____ ☐ CCS _____ ☐ CCM _____ ☐ DM _____

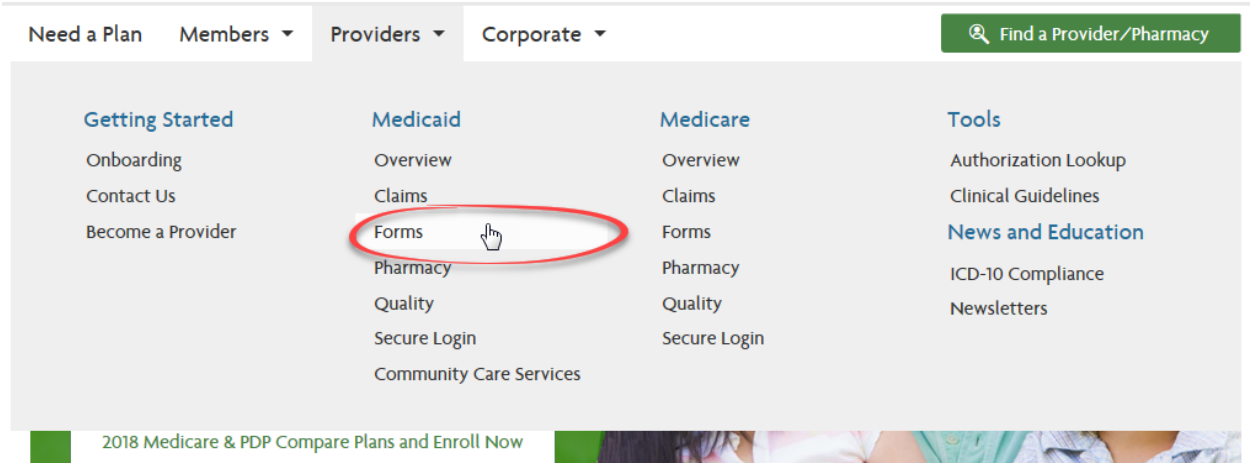
Screened by: _____ Screening Date: _____

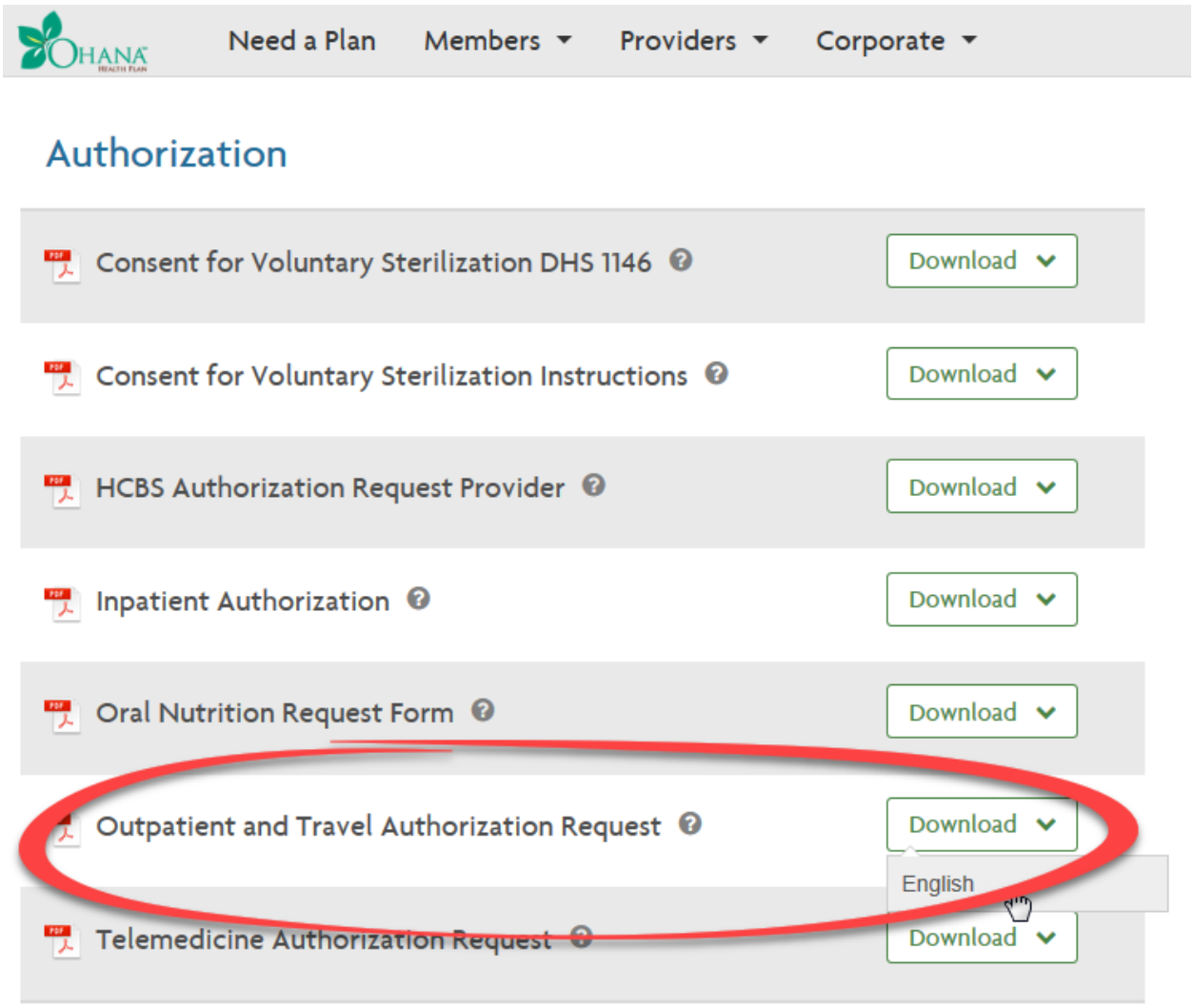
‘Ohana Health Plan Forms

Outpatient and Travel Authorization Request

www.wellcare.com/hawaii



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Providers
Corporate
Authorization
Consent for Voluntary Sterilization DHS 1146
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Consent for Voluntary Sterilization Instructions
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HCBS Authorization Request Provider
Download
Inpatient Authorization
Download
Oral Nutrition Request Form
Download
Outpatient and Travel Authorization Request
Download
English
Telemedicine Authorization Request
Download

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Kapolei, HI 96707

OUTPATIENT AUTHORIZATION REQUEST AND PHYSICIAN REQUEST FOR TRANSPORTATION, LODGING, AND MEALS

Please Fax completed form to: **1-888-881-8225**
Customer Service Phone Numbers: **Medicare** 1-888-505-1201 **Medicaid** 1-888-846-4262

☐ Standard Request	Requests for prior authorization (with supporting clinical information and documentation) should be sent to 'Ohana 14 days prior to the date the requested services will be performed.
☐ Expedited Request **(MD Signature Required)**	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function. **Physician Signature Validating Expedited Request** _____ Date Signed _____

☐ Precertification Request ☐ Payment Determination Request ☐ Out-of-State / Out-of-Network ☐ Off-Island Travel (Complete Page 2)

Contact Information

List contact for any questions or concerns regarding this request:

Contact Name (Last, First) _____ Contact Phone Number _____ Contact Fax Number _____

Member Information

'Ohana ID Number _____ Member Name (Last, First , MI) _____ Date of Birth _____

Member Address _____ Member Phone Number _____

Service / Procedure / Treatment Information

Planned Date of Service: _____ to _____

ICD Dx Codes: _____ _____ _____ _____ _____ _____ _____

Place of Service: ☐ ASC Ambulatory Surgery Center ☐ Outpatient ☐ Office ☐ Home ☐ Other _____

CPT/HCPCS Code(s):

Code	# visits / units	Code	# visits / units	Code	# visits / units	Code	# visits / units
Code	# visits / units	Code	# visits / units	Code	# visits / units	Code	# visits / units

PT/OT/Aqua/Speech Therapy: ☐ Initial Request ☐ Continuing--Last DOS: _____ Total Visits Used: _____

Pregnancy Notification (Global OB Authorization): ☐ High-Risk EDD: _____ 1st Prenatal Visit: _____

Provider Information

Requesting /Referring Provider Name _____ Provider ID _____ Provider Type _____

Provider Address (Including City/State/ZIP Code) _____

Phone Number _____ Fax Number _____

Treating Provider Name _____ Provider ID _____ Specialty _____

Provider Address (Including City/State/ZIP Code) _____

Phone Number _____ Fax Number _____

☐ Check this box to skip this section and have 'Ohana assign the Facility

Facility Provider Name _____ Facility ID _____ Facility Type _____

Facility Address (Including City/State/ZIP Code) _____

Phone Number _____ Fax Number _____

Additional Information: i.e., Clinical Summary, Description of Request, Reason for referral to an Out-of-State/Out-of-Network Provider

Please attach supporting documentation to avoid delays.

*Authorizations will be given for medically necessary services only: it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergencies do not require prior authorization (An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result, without immediate medical attention, in serious jeopardy to the health of an individual). *Urgent Care is defined as medically necessary treatment for an injury, illness, or other type of condition (usually not life-threatening) which should be treated within 24 hours.*

949 Kamokila Boulevard, 3rd floor, Suite 350
Kapolei, HI 96707

OUTPATIENT AUTHORIZATION REQUEST AND PHYSICIAN REQUEST FOR TRANSPORTATION, LODGING, AND MEALS

Please Fax completed form to: **1-888-881-8225**
Customer Service Phone Numbers: **Medicare** 1-888-505-1201 **Medicaid** 1-888-846-4262

Member Name: 'Ohana ID #:

Off-Island Travel Request Information

(Page 2)

Criteria:

- **Member must have Medicaid or CCS with 'Ohana Health Plan**
- **Appointments should be made for Monday through Thursday and no later than 2 p.m.**

Appointment Details Related to Travel		
Treating Provider Address (if different from above):		
Date member must be present:	Start Time:	Additional Info:
Date of expected release:	End Time:	Additional Info:

Travel Details		
Type of Request: ☐ Air ☐ Ferry	Departure Date:	Return Date:
Type of Ticket: ☐ One-way ☐ Round-trip	Departure City/Airport:	Arrival City/Airport:
To assure travel accomodations, please indicate Member's:	Height:	Weight:
Medical reason if stay is longer than one day:		
Lodging Required? ☐ No ☐ Yes	Meals required? ☐ No ☐ Yes	

Attendant Information	
Attendant Required? ☐ No ☐ Yes* **If yes, will require additional 24 hours to process*	Name & Birth date of adult attendant: *(As Listed on Valid Photo ID)*
Medical Reason for Attendant:	

Ground Transportation	
Ground Transportation Required? ☐ No ☐ Yes	Preferred Transportation Provider:
Needed on Home Island? ☐ No ☐ Yes	Needed at Treating Destination? ☐ No ☐ Yes

Medical Needs		
Wheelchair Required? ☐ No ☐ Yes	Has own Wheelchair? ☐ No ☐ Yes	If yes, type:
Oxygen required? ☐ No ☐ Yes	If yes: ☐ Nasal ☐ Mask	O2 flow rate:
Other special travel needs:		

*Authorization will be given for medically necessary services only: it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergencies do not require prior authorization (An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result, without immediate medical attention, in serious jeopardy to the health of an individual). *Urgent Care is defined as medically necessary treatment for an injury, illness, or other type of condition (usually not life-threatening) which should be treated within 24 hours.*

All About Service Coordination

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

Service coordination

offers providers and patients extra support with:

- Health care planning.
- Coordination of services.
- Service implementation.
- Care evaluation and adjustment.

With a lighter administrative burden, the provider team can focus on giving quality care while patients can focus on getting the most out of their care.

Who qualifies for service coordination?

Adults and children with HMSA QUEST Integration who either:

- Receive long-term services and support.
- Have special health care needs.

Who are service coordinators and what do they do?

They're licensed nurses and social workers who:

- Conduct health and functional assessments.
- Develop a service plan based on assessment or reassessment results.
- Monitor Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) progress, if applicable.
- Coordinate services with other providers and community programs, such as:
  - Medicare.
  - Department of Health programs excluded from QUEST Integration.
  - Other Department of Human Services programs such as Child Welfare Services and Adult Protective Services.
  - Medicare Advantage plans.
  - Other health plan providers.
  - Zero-To-Three.
  - Healthy Start.
  - Developmental disability/intellectual disability (DD/ID) providers at the Department of Health.
  - Community Care Services.
  - Child and Adolescent Mental Health Division (CAMHD) programs.
- Provide continuity of care when patients are discharged from a hospital.
- Facilitate access to services, including community services.
- Help resolve concerns about service delivery or providers.
- Help patients maintain Medicaid benefits.
- Refer patients for emotional and behavioral development or serious mental illness (SMI) evaluation, if applicable.

When should I consider service coordination for my patient?

Consider it for children with autism and patients who:

- Have chronic conditions such as asthma, diabetes, hypertension, cancer, or chronic obstructive pulmonary disease.
- Are outliers for emergency room use.
- Are being discharged from an acute care setting.
- Have been readmitted to a hospital within the last 30 days.

Patients may also qualify for service coordination's long-term services and supports (LTSS) if they either:

- Are at risk of moving into an institution.
- Have disabilities and need help maintaining their independence.

How do I get service coordination for my patient?

Complete and submit the form available at hmsa.com/portal/provider/HMSA_QUEST_Integration_Service_Coordination_Referral_Form.pdf.

If you have questions, please call 948-6997 on Oahu or 1 (844) 223-9856 toll-free on the Neighbor Islands.

Your patient's protected health information (PHI) is always guarded.

Service coordinators share information with the patient, the PCP (you), or any caregivers the patient has authorized to receive the information. Only people or agencies that need the information to perform their duties under the QUEST Integration contract have access to the information. Any other party may access confidential information only after complying with the requirements of state and federal laws and regulations, including HIPAA.

An Independent Licensee of the Blue Cross and Blue Shield Association

Please fax completed form to: (808) 944-5604
Or Mail to: HMSA
Health Management Operations - QI
P. O. Box 860
Honolulu, Hawaii 96808-0860
Phone Nos: (808) 948-6997 Oahu
(844) 223-9856 Neighbor Island

HMSA QUEST Integration
Service Coordination Referral Form

REFERRAL INFORMATION

Referred By | Phone Number | Fax Number

Relationship to Member

MEMBER INFORMATION

Membership Number | Member's Name (Last, First, MI) | Date of Birth

Phone | Address

Member's Authorized Representative/Guardian/Caregiver | Phone

PROVIDER INFORMATION

PCP/Specialist Name | Phone Number | Fax Number

REASON FOR REFERRAL

☐ Disability/ADRC/Potential Catastrophic ☐ Medical Needs

☐ Behavioral Health ☐ Substance Abuse

Diagnosis Code(s): _____ _____ _____ _____

For HMSA Use:

Date Received

Referred to: ☐ LTSS ☐ SHCN ☐ SHCN-BH