HANA HOU
MEDICAL GROUP

CASE MANAGEMENT REFERRAL FORM (CMR)

Email to caremanagement@hanahoumedicalgroup.com

Fax to 888 - 847 - 8215

All referrals MUST be faxed to HHMG's UM Department. Please fax all supporting medical documentation with this form.

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ Middle Name: ______________________

Sex: Male ☐ Female ☐ Date of Birth: _____________________ Patient's Preferred Language: ______________________

Health Plan: ___________________________________ ID No. ____________________ Effective Date: ________________

PHYSICIAN INFORMATION

Name of Referring Physician: ____

Telephone Number: ____

Fax Number: ____

Reason for Referral:

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MEDICAL DIAGNOSES	
Diagnosis (ICD-10):	Description:

Additional notes:

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Referring Physician Signature: ____ Date: ___________________________

Notes:

1. This form is only for referral purposes for HHMG in-network physicians.