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

BH INPATIENT ADMISSION NOTIFICATION & FOLLOW-UP

FAX TO: 1-888-481-9739

Member	
BH CM Agency:	Date of Inpatient Notification:
Member Plan ID:	Date of Birth:
Member Last Name:	Member First Name:
QUEST Integration Health Plan:	ʻOhana CCS Primary Contact:

Hospital Admission Information		
Hospital/Facility:		Admitting Diagnosis:
Date of Admission:	☐ Currently Inpatient	Anticipated Discharge Date:

Hospital Discharge Information	
Date of Discharge: _____	Date of Visit while Member was Inpatient: _____
☐ Medical issues identified that may be Special Health Care Needs and may need referral to Service Coordination	
☐ Member's Medical Health Plan was contacted and referral made	

Member Follow-Up Section

BH Care Manager

Name of Care Manager: _____	Contact number: _____
☐ Member's Individualized Treatment Plan updated after inpatient discharge	Date updated: _____
☐ Discussed importance for member to sign consents to release information between PCP and Behavioral Health	

Member should be contacted on a weekly basis for 4 weeks post-discharge to ensure safe transition and reduce readmission.

	Date of Contact	If contact is not made, please indicate reasons or barriers
1st Week Contact		
2nd Week Contact		

*Fax this form to ʻOhana CCS at **1-888-481-9739** within 14 days post-discharge*

	Date of Contact	If contact is not made, please indicate reasons or barriers
3rd Week Contact		
4th Week Contact		

*Fax this form to ʻOhana CCS at **1-888-481-9739** within 30 days post-discharge*

Behavioral Health Provider

Name of Licensed BH Provider: _____	Date of Appt: _____
☐ Appointment occurred within **7** days post-discharge	
If appointment did not occur, please indicate reasons/barriers and reschedule appointment: _____	
Date of Rescheduled Appointment (within 2 weeks): _____	

Primary Care Physician (PCP)

In order to facilitate care coordination between PCP and BH Provider, allow for medication reconciliation and follow-up on any needed labs or screenings, this requirement is a DHS contract mandate.

Name of PCP: _____	Date of Appt: _____
☐ Appointment occurred within **14** days post-discharge	
If appointment did not occur, please indicate reasons/barriers and reschedule appointment: _____	
Date of Rescheduled Appointment (within 2 weeks): _____	

Care Manager Signature: _____ Date: _____