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Pain Management Program Referral Form

*Indicates a required field

Requirements: Patients must have a history of chronic low back pain, a current opioid prescription or a history of opioid abuse or overuse *Clinical information and supportive documentation should consist of current physician order, notes and recent diagnostics. Notification is required for any date of service change.*

Expedited Requests: If the standard time for making a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call **1-888-846-4262**.

Email completed form to: ohanareferrals@ashn.com

Requestor Name: _____ Fax*: _____ Phone*: _____ Effective Date*: _____

MEMBER INFO (Please Print)			
'Ohana ID*:		Medicaid ID:	
Last Name*:	First Name, MI*:	Date of Birth*: / /	
Member Email Address:		Member Primary Language:	
Member Preferred Phone Number:		Member Preferred Time to be called: AM DAY PM EVE	
Member confirmed interest in participating in a non-pharmaceutical pain management program: Yes <input type="checkbox"/>			
Member agrees to allow referral vendor to outreach to member: Yes <input type="checkbox"/> No <input type="checkbox"/>			
REQUESTING 'OHANA HEALTH COORDINATOR (Please Print)			
Primary Health Coordinator Name:			
Email Address:		Phone Number:	
REQUESTING MEDICAL PROVIDER (Please Print)			
'Ohana ID:		NPI/Tax ID*:	
Provider Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:
LOW BACK PAIN DIAGNOSIS CODES being treated by MD*			
Criteria – Chronic Low Back Pain and Current Opioid prescription or recent history of opioid abuse or overuse			
ICD-10:	ICD-10:	ICD-10:	ICD-10:
Chronic Pain: <input type="checkbox"/>	Current Opioid Prescription: <input type="checkbox"/>		
REQUESTED SERVICES			
Date of Most Recent Visit with Requesting MD Provider:			
Suggested Services	Clinical Considerations / Physician Goals for Patient		
Acupuncture: <input type="checkbox"/> Massage Therapy: <input type="checkbox"/> Chiropractic Services: <input type="checkbox"/> Pain Management Coaching: <input type="checkbox"/> <i>Select any service that patient may be interested in pursuing or physician recommends</i>			
Please return for PCP follow-up in ____ months, or as determined by treating provider.			

SERVICING PROVIDER OR FACILITY (Please Print)

Ohana ID:	NPI/Tax ID*:	
Provider/Facility Name*:	Address:	
City, State, ZIP:	Fax*:	Phone: