HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

HWMG
HAWAII-WESTERN MANAGEMENT GROUP, INC.
Third-Party Administrator

Registration Form for Providers

Provider Name:	
TIN #:	NPI:
DOB:	Non-English Language Spoken:

Provider Type

Specialty:	Primary: ______________________________ Secondary: ______________________________

Provider Address Information (Complete only if specific contracted TIN has multiple locations)

Primary Practice Address		Additional Practice Address	
Practice Name:		Practice Name:	
Address:		Address:	
Contact Name:		Contact Name:	
Phone:		Phone:	
Fax:		Fax:	

Professional Licensure List ALL (past, present, and pending) professional licenses

State	License Number	Date Issued / /	Valid Through / /
State	License Number	Date Issued / /	Valid Through / /

State Controlled Substance and Federal Drug Enforcement Administrator (DEA) Certification

CSC Number	State	Valid Through / /
DEA Number	State	Valid Through / /

Liability Insurance Coverage

Insurance Carrier Name			
Address	City	State	Zip Code
Policyholder Name		Policy Number	
Expiration / /	Amount of Coverage per Occurrence	Aggregate	

Membership

AcuPlan Member? ☐Yes ☐ No	HIDA Member? ☐Yes ☐ No

PR Ext-93 10 0310 062311

I certify that all information provided by me in my application is true, correct, and complete. If there are any changes to the information, I will notify HWMG within thirty (30) days of any changes to the information.

I understand that any misstatement or omission in the application may result in the withdrawal of the application from consideration.

I agree to participate in the HMAA Provider Network and understand an agreement is not effective until accepted by HWMG.

Signature: ____ Date: ___________________

HWMG
HAWAII-WESTERN MANAGEMENT GROUP, INC.
Third-Party Administrator

Standard Authorization, Attestation, and Release

(PLEASE READ CAREFULLY BEFORE SIGNING)

In connection with this application for participation in the HMAA Network, which is owned and operated by Hawaii-Western Management Group (HWMG), I understand and acknowledge that it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by HWMG for Participation.

I further acknowledge that I am responsible for knowing the contents of the applicable bylaws, rules and regulations, and requirements of HWMG and its professional/medical staff/network, and agree to be bound by them in application process and if granted Participation.

1. **Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize HWMG and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualification for Participation and authorize such third parties to release such information to HWMG and/or its Agents.
2. **Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any health care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary information about any disciplinary action taken against me to HWMG and/or its Agents, and as otherwise may be required by law. I hereby further authorize HWMG to release Disciplinary information about any disciplinary action taken against me to its participating entities at which I have Participation, and as otherwise may be required by law. As used herein, Disciplinary Information means information concerning (i) any action taken by such health care organization, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition my Participation or impose a corrective action plan; (ii) any other disciplinary actions involving me including but not limited to discipline in the employment context; or (iii) my registration prior to the conclusion of any disciplinary proceeding or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.
3. **Release from Liability.** I hereby further release from liability HWMG and its Agents, HMAA, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunity provided by law for peer review activities.

I understand and agree that HWMG may communicate with me via e-mail over the internet regarding my application for credentialing. I understand that unencrypted, unauthorized Internet e-mail is inherently insecure. I further understand that Internet messages may be corrupted or incomplete, or may incorrectly identify the sender.

I understand and agree that this Authorization and Release is irrevocable for any period during which I am an applicant for Participation with HMAA, or I am a member of HWMG's medical or health care staff, or an HMAA participating provider. I agree to execute consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide consent may be grounds for termination or discipline by HWMG in accordance with the applicable bylaws, rules and regulation, and requirements of HWMG.

I acknowledge that the investigation of information in this application and the release and exchange of Disciplinary Information by HWMG and its agents are done to achieve, maintain and improve quality patient care.

All information provided by me in this Application is true to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial or revocation of Participation. I understand and acknowledge that HWMG shall be solely responsible for all decisions concerning the granting of Participation.

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization, Attestation, and Release shall be as effective as the original.

Signature: ____ **Date:** __________________

Name (please print): ___________________________________

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