



## Provider Contracting Application

Please accurately and legibly complete all sections of this Provider Contracting Application. All non-applicable sections should be marked with "N/A". Incomplete applications or missing documents will delay your application process. Kindly retain a copy of the submitted application for your files.

**When you have completed and signed the Provider Contracting Application, return the completed Application and all required documents to:**

HWMG  
 Provider Network Management Department  
 737 Bishop Street, Suite 1200  
 Honolulu, HI 96813  
  
 Phone: (808) 591-0088 ext. 304  
 Toll-Free: (800) 621-6998 ext. 304  
 Fax: (808) 591-0463  
 Email: [ProviderServices@hmaa.com](mailto:ProviderServices@hmaa.com)

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### General Practice Information

Practitioner Last Name	First Name	MI	Suffix	Degree
Business Name as it appears on W-9		Taxpayer Identification Number _____		
Name of Practice or Clinic/Group/Facility (if different from Business Name)		National Provider Identifier Number _____		
Address as it appears on W-9		City	State	Zip Code
Type of Practice (check one only; if other, please specify)				
<input type="checkbox"/> Practitioner based within a Clinic/Group/Facility		<input type="checkbox"/> Independent Practice	<input type="checkbox"/> Clinic	
<input type="checkbox"/> Durable Medical Equipment/Supplies Provider		<input type="checkbox"/> Group Practice	<input type="checkbox"/> Hospital	<input type="checkbox"/> Other Facility
<input type="checkbox"/> Other (please specify): _____				
Method of Claim Submission				
Does your practice submit claims electronically? <input type="checkbox"/> Yes, through: _____ <input type="checkbox"/> No <span style="margin-left: 150px;"><small>(Name of Clearinghouse/Vendor)</small></span>				
Contact Person's name for Claim Submission: _____    Phone Number: _____				

<b>HMAA/HWMG USE ONLY</b>
<input type="checkbox"/> Indep. <input type="checkbox"/> Group <input type="checkbox"/> Facility <input type="checkbox"/> DME <input type="checkbox"/> Dental <input type="checkbox"/> Practitioner
EFFECTIVE DATE: _____

**Primary Practice Information**
**Location Information**

Name of Office		
Street Address	City	State Zip Code
Address above also applies to:		
<ul style="list-style-type: none"> <li>• Mailing? <input type="checkbox"/> Yes <input type="checkbox"/> No - Mailing address: _____</li> <li>• Billing? <input type="checkbox"/> Yes <input type="checkbox"/> No - Billing address: _____</li> </ul>		
Appointment Phone Number <i>(to be listed in Provider Directory)</i>	Fax Number <i>(for office-use only)</i>	E-mail Address <i>(for office-use only)</i>
Phone Number above also applies to:	Fax Number above also applies to Billing?	E-mail above also applies to Billing?
<ul style="list-style-type: none"> <li>• Office? <input type="checkbox"/> Yes <input type="checkbox"/> No - Office phone: _____</li> <li>• Billing? <input type="checkbox"/> Yes <input type="checkbox"/> No - Billing phone: _____</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No - Billing fax: _____</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No - Billing e-mail: _____</li> </ul>
Office Contact Person & Job Title		
Make Checks Payable To		
Office Hours		
Mon: ___:___ - ___:___    Tue: ___:___ - ___:___    Wed: ___:___ - ___:___    Thu: ___:___ - ___:___    Fri: ___:___ - ___:___ Sat: ___:___ - ___:___    Sun: ___:___ - ___:___    Other (please specify) _____: ___:___ - ___:___		

1. Do the Provider and/or Office Personnel speak any languages other than English to treat patients?  Yes  No  
 If yes, specify language(s): \_\_\_\_\_
2. Is this office:
  - Shared with other participating providers? If yes, please indicate provider name(s):  Yes  No  
 \_\_\_\_\_
  - Accepting new patients?  Yes  No
  - Equipped to meet Americans with Disabilities Act requirements?  Yes  No
  - Offering Lab services  Yes  No
3. [For Dental Providers only] Are you a member of Hawaiian Independent Dental Alliance (HIDA)?  Yes  No
4. [For Acupuncturists only] Are you a member of Acuplan?  Yes  No

**All practice locations must be listed. If there are more than 2 locations, please make copies of this page and complete all required information for each practice location.**

**Additional Practice Information**
**Location Information**

Name of Office		
Street Address	City	State Zip Code
Address above also applies to:		
• Mailing? <input type="checkbox"/> Yes <input type="checkbox"/> No - Mailing address: _____		
• Billing? <input type="checkbox"/> Yes <input type="checkbox"/> No - Billing address: _____		
Appointment Phone Number <i>(to be listed in Provider Directory)</i>	Fax Number <i>(for office-use only)</i>	E-mail Address <i>(for office-use only)</i>
Phone Number above also applies to:	Fax Number above also applies to Billing?	E-mail above also applies to Billing?
• Office? <input type="checkbox"/> Yes <input type="checkbox"/> No - Office phone: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
• Billing? <input type="checkbox"/> Yes <input type="checkbox"/> No - Billing phone: _____	<input type="checkbox"/> No - Billing fax: _____	<input type="checkbox"/> No - Billing e-mail: _____
Office Contact Person & Job Title		
Make Checks Payable To		
Office Hours		
Mon: ___:___ - ___:___ Tue: ___:___ - ___:___ Wed: ___:___ - ___:___ Thu: ___:___ - ___:___ Fri: ___:___ - ___:___		
Sat: ___:___ - ___:___ Sun: ___:___ - ___:___ Other (please specify) _____: _____: - _____:_____		

1. Do the Provider and/or Office Personnel speak any languages other than English to treat patients?  Yes  No

If yes, specify language(s): \_\_\_\_\_

2. Is this office:

• Shared with other participating providers? If yes, please indicate provider name(s):  Yes  No

\_\_\_\_\_

• Accepting new patients?  Yes  No

• Equipped to meet Americans with Disabilities Act requirements?  Yes  No

**Liability Insurance Coverage (please attach proof of coverage)**

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

**Disclosure Questions (This section only applies to Clinics and Groups)**

- Does your practice have and maintain in good standing all **appropriate state and federal licenses**, permits, registrations, certifications, credentials, and any other documents necessary to perform health care services?  Yes  No
  - If NO, please explain: \_\_\_\_\_
- Does your practice verify, for **each Physician employed** under your practice, the credentials necessary to perform health care services?  Yes  No
  - If NO, please explain: \_\_\_\_\_
- If YES to question #3 above, please indicate how your practice conducts the **credentialing process** for each Physician:
  - We perform credentialing procedures internally.
  - We outsource/delegate credentialing procedures to \_\_\_\_\_  
(Name of Company)
  - Other (please specify): \_\_\_\_\_

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**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: \_\_\_\_\_**