

## Participating Provider Add, Delete or Change Form

**Effective Date of Change:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_      **Pay to:** \_\_\_\_\_

**Please complete this form when adding, deleting, or changing information for an existing participating Provider or Practice.**

**Please see checklist below of all documents required ONLY when adding a New Provider:**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>✓ Copy of completed Change Form</li> <li>✓ Copy of each practitioner's Hawaii State License</li> <li>✓ Copy of Signed Authorization, Attestation and Release Form from each practitioner being added (see page 3)</li> <li>✓ Copy of Liability Insurance with each practitioner's name</li> </ul> | <ul style="list-style-type: none"> <li>✓ Copy of each practitioner's Federal or State DEA License</li> <li>✓ Copy of each practitioner's NPI Notification</li> <li>✓ Copy of W-9, if requesting a TIN change (form available on <a href="http://www.hmaa.com">www.hmaa.com</a> under Forms and Information/Providers)</li> </ul> |
|--|--|

### Complete this section if adding, deleting, or changing Practitioner Information

<b>Request Type</b>	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	<b>Effective Date</b> (if different from above)
<b>Practitioner Information</b>	<b>Current</b>	<b>Change To</b>
<b>Last Name</b>	_____	_____
<b>First Name, M.I. &amp; Title</b>	_____	_____
<b>SSN</b>	_____	_____
<b>Date of Birth</b>	_____	_____
<b>Tax Identification # (TIN)</b>	_____	_____
<b>Specialties</b>	<input type="checkbox"/> Primary _____ <input type="checkbox"/> Secondary _____	<input type="checkbox"/> Primary _____ <input type="checkbox"/> Secondary _____
Accept New Patients	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIDA Member (Dentists Only) <input type="checkbox"/> Yes <input type="checkbox"/> No
AcuPlan Member(Lab Only)	<input type="checkbox"/> Yes <input type="checkbox"/> No	List Non-English Languages Spoken _____

<b>Request Type</b>	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	<b>Effective Date</b> (if different from above date)
<b>Practitioner Information</b>	<b>Current</b>	<b>Change To</b>
<b>Last Name</b>	_____	_____
<b>First Name, M.I. &amp; Title</b>	_____	_____
<b>SSN</b>	_____	_____
<b>Date of Birth</b>	_____	_____
<b>Tax Identification # (TIN)</b>	_____	_____
<b>Specialties</b>	<input type="checkbox"/> Primary _____ <input type="checkbox"/> Secondary _____	<input type="checkbox"/> Primary _____ <input type="checkbox"/> Secondary _____
Accept New Patients	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIDA Member (Dentists Only) <input type="checkbox"/> Yes <input type="checkbox"/> No
AcuPlan Member(Lab Only)	<input type="checkbox"/> Yes <input type="checkbox"/> No	List Non-English Languages Spoken _____

**Complete this section if adding, deleting, or changing Practice information**

*(All Practice locations must be listed when adding a practitioner. If there are more than 2 locations, please make copies of this page and complete all required information for each Practice location)*

<b>Request Type</b>	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	<b>Effective Date of Change</b> (if different from shown on page 1)
<b>Address Information</b>	<b>Current</b>	<b>Change To</b>
<b>Address Type</b> <input type="checkbox"/> Correspondence Address <input type="checkbox"/> Billing/Remittance Address <input type="checkbox"/> Physical Address <input type="checkbox"/> W-9 Address (must submit a new W-9 form)	Street: _____ City: _____ Zip: _____	Street: _____ City: _____ Zip: _____
<b>Contact Information</b> <b>Contact Type</b> <input type="checkbox"/> Correspondence Address <input type="checkbox"/> Billing/Remittance Address <input type="checkbox"/> Physical Address	Contact Name: _____ Office Phone: _____ Fax Number: _____ Email Address: _____	Contact Name: _____ Office Phone: _____ Fax Number: _____ Email Address: _____

<b>Request Type</b>	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	<b>Effective Date of Change</b> (if different from shown on page 1)
<b>Address Information</b>	<b>Current</b>	<b>Change To</b>
<b>Address Type</b> <input type="checkbox"/> Correspondence Address <input type="checkbox"/> Billing/Remittance Address <input type="checkbox"/> Physical Address <input type="checkbox"/> W-9 Address (must submit a new W-9 form)	Street: _____ City: _____ Zip: _____	Street: _____ City: _____ Zip: _____
<b>Contact Information</b> <b>Contact Type</b> <input type="checkbox"/> Correspondence Address <input type="checkbox"/> Billing/Remittance Address <input type="checkbox"/> Physical Address	Contact Name: _____ Office Phone: _____ Fax Number: _____ Email Address: _____	Contact Name: _____ Office Phone: _____ Fax Number: _____ Email Address: _____
Checks Payable to	Change to:	
Other Changes	Other changes:	

**I certify that all information provided by me in this Provider Add, Delete, and Change Form is true, correct, and complete. If there are any changes to the information, I will notify HWMG within thirty (30) days of the change.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Send all 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)



## 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 Internet Electronic Mail (e-mail) 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): \_\_\_\_\_