HMSA
Blue Cross Blue Shield of Hawai'i
An Independent Licensee of the Blue Cross and Blue Shield Association

AGENT AUTHORIZATION

To authorize a billing agent or staff member to sign claims forms for your practice.

In consideration of HMSA's willingness to permit the below-named person(s) to execute, on my behalf and as my agent(s), the CMS 1500 and/or UB-04 claim form, I agree to accept full responsibility for their accuracy and propriety, and in particular, I understand that the execution of each or either shall constitute a certification that the professional services indicated were rendered by me, that the charges are proper and correct and that no payments have been received except as noted. I further agree that in the event HMSA suffers any loss because of an improper or inaccurate form submission, I will reimburse HMSA for such loss including costs incurred, if any, to recover said loss.

It is also understood that the appointment of the below-named person(s) as my agent(s) shall remain in effect, and may be conclusively relied upon by HMSA, until such time as HMSA receives cancellation thereof executed in writing either by me or my said agent(s).

HMSA Provider Name: _____

HMSA Provider Number: _____
(If applicable)
Phone Number: _____

Office Address: _____

Provider Signature: _____ Date: _____
(Required)

Signature(s) and name of agent(s) authorized to execute and deliver the CMS 1500 claim form and/or the UB-04 claim form are as follows:

Print Name: _____ Signature of Agent _____
☐ CMS 1500 ☐ UB-04
Print Name: _____ Signature of Agent _____
☐ CMS 1500 ☐ UB-04
Print Name: _____ Signature of Agent _____
☐ CMS 1500 ☐ UB-04

Please mail this completed form to: Fax to: (808) 948-8210 or email to provider_data@hmsa.com
HMSA
ATTN: Provider Services-PDCA
PO BOX 860
Honolulu HI 96808-0860

Please retain a copy of this document for your records.