HMSA

Blue Cross Blue Shield of Hawai'i

An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA PROVIDER ENROLLMENT FORM

NONPARTICIPATING

PLEASE TYPE OR PRINT USING BALLPOINT PEN.
(All non-applicable sections should be marked with "N/A.")

Provider # _____
(HMSA use only)

I. Personal Information

Legal Name				
1. First	2. Middle	3. Last	4. Suffix	5. Title

6. Social Security No.	7. Date of Birth	8. Gender: ☐ Male ☐ Female
9. Contact Phone No. (optional)	10. Email Address	11. Individual NPI

12. Medicare CMS Status: ☐ Participating ☐ Nonparticipating ☐ Opt out ☐ In process for: ☐ Participating ☐ Nonparticipating

13. Marketing Specialty

II. Office Information/Location of Practice

☐ **Main** ☐ **Additional** ☐ **Hospitalist** NOTE: If you have additional locations, please submit a copy of this page for each location.

1. Office Practice Name	2. Are you: ☐ The Owner ☐ Employed ☐ Contracted		
3. Street	4. City	5. State	6. ZIP

7. Clinical Lab Inspection Approval (CLIA) No.:	8. CLIA Start/End Dates Start: End:

Mailing (Correspondence) Address (same mailing address for all locations)	9. Entity Name:			
10. Street (or P.O. Box)		11. City	12. State	13. ZIP
Payment Address	14. Street (or P.O. Box)	15. City	16. State	17. ZIP

18. Office Telephone (Appointments) (will be published in the directory)	19. Office Manager Name	20. Office Manager Telephone	21. Office Fax	22. Referral Fax

II. Office Information/Location of Practice

23. Clinic or Group Name	Group NPI	24. Federal Tax ID #	25. Effective Date of This Practice Location

26. Payment Checks Should be Made Out to:	27. Mail Payment Check to:
☐ Provider ☐ Clinic or group ☐ Provider's office practice name ☐ Other (specify): _____	☐ Payment address ☐ Office address ☐ Mailing address

28. Handicap Accessibility: ☐ Yes ☐ No	29. Number of Office Staff (Including provider)	

III. Professional Licensure *(List ALL active and inactive professional licenses.)*

Number	State	Date Issued	Expiration
Number	State	Date Issued	Expiration
Number	State	Date Issued	Expiration
Number	State	Date Issued	Expiration

IV. Attestation

I hereby affirm that the above information is complete, accurate, and true, to the best of my information, knowledge, and belief.

Signature _____ Date _____

Printed or Stamped Name _____

Please return application to:

Hawai'i Medical Service Association
Attn: Provider Services, PDCA Unit - Rm 509
P.O. Box 860
Honolulu, HI 96808-0860

Phone: 948-6330 on Oahu
1 (800) 790-4672 toll-free on the Neighbor Islands
Fax: 948-8210 on Oahu
Email: Provider_data@hmsa.com