AlohaCare
Aloha is the difference

BEHAVIORAL HEALTH PROVIDER PROFILE FORM

Thank you for your interest in contracting with AlohaCare to serve our AlohaCare QUEST, AlohaCare Advantage and/or AlohaCare Advantage Plus members. In order to begin the process of joining AlohaCare's Provider Network, we ask that you complete the attached AlohaCare Provider Profile.

Provider Profiles differ by provider categories: Primary Care, Specialist, Behavioral Health and Physician Assistant. **Please verify that you have the correct Provider Profile before starting.**

Please complete the attached Provider Profile and return it to AlohaCare with the documents requested below:

- Complete Credentialing Application if you are a new provider applying for AlohaCare participation
- Copy of current Hawaii State Professional License
- Copy of current Professional Liability Insurance (1M/3M)

  Note: Minimum requirements for Professional Liability Insurance is $1 million per claim with $3 million in the annual aggregate.
- Copy of current Hawaii State (CSC) license (if applicable)
- Copy of current Federal DEA license (if applicable)
- Completed W-9 Form
- Copy of CV or Resume

Fax or mail copies of the completed Provider Profile, with additional documents to:

Fax: (808) 973-0203

Address: AlohaCare
ATTN: Provider Contracts
1357 Kapiolani Blvd., Suite 1250
Honolulu, Hawaii 96814

Once we have received the necessary paperwork, we will initiate the formal credentialing and contracting processes. **Providers must be credentialed by AlohaCare prior to rendering care or services to AlohaCare members. Services rendered to AlohaCare members prior to the completion of credentialing and provider notification of acceptance into the AlohaCare provider network will not be honored for payment.**

Please contact our Provider Relations Department at 973-1650 (Oahu) or 1-800-434-1002 (Neighbor Islands) if you have any questions regarding these forms or instructions.

BEHAVIORAL HEALTH PROVIDER PROFILE FORM

LAST NAME | FIRST NAME | MI | PROFESSIONAL DEGREE

SS# | D.O.B. | GENDER | NPI# | EMAIL ADDRESS

Check the Program(s) you will participate with: ☐ QUEST ☐ Medicare (AlohaCare Advantage plans)

REQUIRED INFORMATION FOR ALL PARTICIPANTS

PRIMARY

SERVICE ADDRESS | CITY | STATE | ZIP CODE

PHONE | FAX | CONTACT PERSON

Check payable to: _____

PAY ADDRESS | CITY | STATE | ZIP CODE

PHONE | FAX | GROUP NPI ID# | TAXPAYER ID#

SECONDARY

If there are additional service addresses, please list on separate attachment.

SERVICE ADDRESS | CITY | STATE | ZIP CODE

PHONE | FAX | CONTACT PERSON

Check payable to: _____

PAY ADDRESS | CITY | STATE | ZIP CODE

PHONE | FAX | GROUP NPI ID# | TAXPAYER ID#

REGULAR CORRESPONDENCE ADDRESS:

☐ Same as Service address ☐ Same as Pay-To address

☐ Other _____

CREDENTIALING CORRESPONDENCE ADDRESS:

ADDRESS | CITY | STATE | ZIP CODE

PHONE | FAX | CONTACT PERSON | EMAIL ADDRESS

MISCELLANEOUS:

1) Do you accept the following patients? ☐ Children ☐ Adolescents Adults

2) Number of patients you will accept: _____

3) Do you have downstream contracted providers? ☐ Yes ☐ No ☐ Not Applicable

A downstream provider is a subcontractor with whom you have a separate agreement to provide services through your practice, group, or organization and who will provide services to AlohaCare members. This does not include your employees, only non-employee practitioners you have contracted with to provide services.

Please list your Primary and Secondary Specialties and Board Certification Numbers.

1. _____
PRIMARY SPECIALTY | CERTIFICATION NO.

2. _____
SECONDARY SPECIALTY | CERTIFICATION NO.

Where do you practice? (For example: private office, clinic, hospital, etc.) _____

_____
OFFICE MANAGER | PHONE

Does the provider speak any foreign language? If yes, please list language(s) spoken.

(For reporting purposes)

1. _____ 2. _____ 3. _____

Does the staff speak any foreign language? If yes, please list language(s) spoken.

(For reporting purposes)

1. _____ 2. _____ 3. _____

Special Notes (unique aspects of your practice):

_____

_____

Please List Name(s) of On-Call Providers:

(On-Call Providers are providers you authorize to care for your AlohaCare members when you are not available. You must make specific coverage arrangements with one or more On-Call Providers during each planned absence and notify AlohaCare accordingly.)

1. _____

NAME PHONE FAX

_____

ADDRESS CITY STATE ZIP CODE

2. _____

NAME PHONE FAX

_____

ADDRESS CITY STATE ZIP CODE

Please list all affiliations with Groups/Doctors:

1. _____

NAME PHONE FAX

_____

ADDRESS CITY STATE ZIP CODE

2. _____

NAME PHONE FAX

_____

ADDRESS CITY STATE ZIP CODE

AGREEMENT

I hereby affirm that I am eligible to participate in state and federally funded programs and that I will notify AlohaCare in the event that I or any individual covered under my (or the group) contract becomes debarred, suspended, or otherwise excluded from participating in state and federally funded programs. The information and/or documentation provided in this form is correct, complete and current to the best of my knowledge. I understand that I must be credentialed by AlohaCare prior to rendering care or services to AlohaCare members. I understand services rendered to AlohaCare members prior to the completion of my credentialing and provider notification of acceptance into the AlohaCare provider network will not be honored for payment.

_____

SIGNATURE PRINT NAME DATE

PHYSICIANS - SEE NEXT PAGE FOR ADMITTING PRIVILEGES

THIS QUESTION IS FOR PHYSICIANS ONLY: ADMITTING PRIVILEGES

Where do you have admitting privileges? (If you do ***not*** have admitting privileges, please complete next section.)

1. _____ 2. _____ 3. _____

ARRANGEMENTS FOR HOSPITAL ADMITTING PRIVILEGES (Physicians Only)

If you do **NOT** have hospital admitting privileges, you are required to have a written arrangement(s) with another provider who has admitting privileges with an acute care hospital within the AlohaCare Network and on the island of service. Please list the physician name(s) and their information below, along with a written copy of such agreement.

1. _____
NAME PHONE FAX PRIVILEGES

_____
ADDRESS CITY STATE ZIP CODE

2. _____
NAME PHONE FAX PRIVILEGES

_____
ADDRESS CITY STATE ZIP CODE

3. _____
NAME PHONE FAX PRIVILEGES

_____
ADDRESS CITY STATE ZIP CODE

PLEASE SIGN THE AGREEMENT ON PAGE 4 SO THAT YOUR REQUEST CAN BE PROCESSED.

DISCLOSURE OF INFORMATION – QUEST PROVIDERS

IMPORTANT

To be Completed by Practitioners Not Contracted Under an Existing AlohaCare Medical Group Practice Agreement

BACKGROUND

The Hawaii Med-QUEST division in accordance with the federal regulations set forth in 42 CFR §455 Subpart B has mandated that AlohaCare obtain the following disclosures from all of our participating providers in order to confirm that no excluded persons are working as managing employees or have an ownership or controlling interest in their medical practice or organization.

If the provider or any managing employee or owner is found to be on the list of excluded individuals maintained by the Department of Health and Human Services Office of Inspector General (OIG), the System for Award Management (SAM), or the excluded parties list maintained by Med-QUEST, AlohaCare must terminate the provider's participation in QUEST and Medicare programs.

INSTRUCTIONS

Please complete all applicable fields and answer the accompanying questions on the disclosure form. List each individual or corporation with a 5% or more ownership or control interest in the provider business entity along with information requested. In addition, please supply the requested information for all managing employees. The definitions below are listed for your convenience (see, 42 CFR §455 Subpart B).

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that (a) has an ownership interest totaling 5 percent or more in a disclosing entity; (b) has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (c) has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; (d) owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; (e) is an officer or director of a disclosing entity that is organized as a corporation; or (f) is a partner in a disclosing entity that is organized as a partnership.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Please attach additional pages as needed to submit all of the required information.

Please return the signed and dated form to AlohaCare with your Provider Profile.

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DISCLOSURE OF INFORMATION STATEMENT

Disclosure of information is required for all participating providers to comply with MedQUEST and federal regulations set forth in 42 CFR §455 Subpart B. List each individual or corporation with a **5% or more ownership or control interest** in the provider business entity and answer the questions for the applicable sections. In addition, please provide the requested information for managing employees. Attach additional sheets if needed to include each owner.

PROVIDER ENTITY NAME (Including DBA, if applicable):

_____

ADDRESS: _____

NPI NUMBER: _____ **TAX ID:** _____

SECTION I OWNER (Individual)

Name (Individual):	
Date of Birth:	Social Security Number:
Address:	
Are you related to another person with an ownership or control interest in the provider entity as a spouse, parent, child, or sibling? Yes ☐ or No ☐	
Do you have an ownership or control interest in a subcontractor of the provider entity? Yes ☐ or No ☐	
If yes, do you have a 5 percent or more interest in that subcontractor? Yes ☐ or No ☐	
Name any other providers (individual or group practices) in which you have an ownership or control interest:	
Have you been convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs? Yes ☐ or No ☐	

SECTION II OWNER (Corporation)

Name (corporation):
Primary business address:
P.O. Box (if applicable):
Other business location addresses:
Tax Identification Number:
a. Please provide the tax identification number of another entity with an ownership or control interest in any subcontractor of the provider if the provider has a 5 percent or more interest in that subcontractor:
b. Is the corporation related to another person with an ownership or control interest in the provider as a spouse, parent, child, or sibling? Yes ☐ or No ☐

c. Does the corporation have an ownership or control interest in a subcontractor of the provider? Yes ☐ or No ☐ If yes, does the corporation have a 5 percent or more interest in that subcontractor? Yes ☐ or No ☐
d. Name any other providers (individual or group practices) in which the corporation has an ownership or control interest:

SECTION III: MANAGING EMPLOYEE INFORMATION

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.	
Name:	
Date of Birth:	Social Security Number:
Address:	
Start Date of Managing Employee:	End Date:
Has the managing employee been convicted of a criminal offense related to his or her involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs? Yes ☐ or No ☐	

☐ I do not have any managing employees or owners to report on the Disclosure of Information Statement.

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

_____ _____

Signature Date

_____

Printed Name