



FACILITY & ANCILLARY 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.

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

- OHCA License (if applicable)
- Copy of accreditation or certificate, along with accompanying report for levels of care to be provided
- Copy of accreditation corrective action plan, if applicable
- Copy of Medicare approval/certificate (if providing services to Medicare members)
- Copy of current Professional Liability Insurance

Note: Minimum requirements for Professional Liability Insurance is \$1 million per claim with \$3 million in the annual aggregate.

- Completed W-9 Form

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

Fax: (808) 973-0811

Address: AlohaCare

ATTN: Provider Relations Department

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.

FACILITY & ANCILLARY PROVIDER PROFILE FORM

ENTITY NAME

FED. ID#

NPI #

QUEST PROVIDER ID#

MEDICARE ID#

Check the Program(s) you will participate with: QUEST Medicare (AlohaCare Advantage plans)
Claims will be submitted on: Form 1500 Form UB

REQUIRED INFORMATION FOR ALL INSTITUTIONAL FACILITIES

Acute:

FED. ID#

NPI #

QUEST PROVIDER ID#

MEDICARE ID#

SNF:

FED. ID#

NPI #

QUEST PROVIDER ID#

MEDICARE ID#

Swing:

FED. ID#

NPI #

QUEST PROVIDER ID#

MEDICARE ID#

Home Health Agency:

FED. ID#

NPI #

QUEST PROVIDER ID#

MEDICARE ID#

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
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PHONE	FAX	CONTACT PERSON
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Check payable to: _____

PAY ADDRESS	CITY	STATE	ZIP CODE
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PHONE	FAX	GROUP NPI ID#	TAXPAYER ID#
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REGULAR CORRESPONDENCE ADDRESS:

- Same as Service address Same as Pay-To address
 Other _____

CREDENTIALING CORRESPONDENCE ADDRESS:

ADDRESS	CITY	STATE	ZIP CODE
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PHONE	FAX	CONTACT PERSON	EMAIL ADDRESS
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AGREEMENT

I hereby affirm that the Provider or Facility is 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.

PROVIDER/AUTHORIZED FACILITY REP. SIGNATURE	PRINT NAME	DATE
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