PRIMARY CARE PHYSICIAN (PCP) 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. <u>This profile document is for PCPs only.</u>

If you are a Specialist, Behavioral Health provider, Physician Assistant, Facility or Ancillary provider, you must complete the appropriate profile document that applies to your specialty. **Please verify that you have the correct provider profile before starting.**

Please return your completed Provider Profile with all required documents requested below:

- 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) 973-0811

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.

PRIMARY CARE PHYSICIAN (PCP) 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 provide EPSDT Services? ☐ Yes ☐ No

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

3) Number of patients you will accept: ______________________

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):

____

____

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

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.) Please sign the last page so that your request can be processed.

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