PHYSICIAN ASSISTANT 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:

- Copy of current Hawaii State Professional License
- 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.
- 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.

PHYSICIAN ASSISTANT 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):

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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

SEE NEXT PAGE FOR SUPERVISING PHYSICIAN ATTACHMENT.

SUPERVISING PHYSICIAN ATTACHMENT

I, ______________________________ , agree to be the supervising physician for

SUPERVISING PHYSICIAN NAME

______________________________ .

PHYSICIAN ASSISTANT NAME

In accordance with regulations set by the Hawaii Board of Medical Examiners, I agree to be responsible for the overall management, direction, and supervision of the named Physician Assistant. I agree to be either physically present or available via telecommunication when the named Physician Assistant is with a patient. I agree to review all of the named Physician Assistant's records involving patient care within seven (7) working days of the provision of medical services. I agree to supervise no more than two physician assistants at any one time.

If I should be unavailable due to sickness, vacation, or other reasons, I will designate a physician in my absence. If I should resign as supervising physician, I agree to give thirty (30) days notice so that a replacement supervising physician can be found. Termination of this attachment does not alter or modify the existing contract in any way.

Supervising Physician Information:

SPECIALITY	PHONE		FAX
ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE	PRINT NAME		DATE