# 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) 973-0204 or 1-866-973-0204

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 feel free to contact our Provider Relations Department should you have any questions regarding these forms or instructions at 973-1650 or 1-800-434-1002 (toll-free from Neighbor Islands).

# PHYSICIAN ASSISTANT PROVIDER PROFILE FORM

**Name:** ______________________________________________________________
LAST FIRST MI PROFESSIONAL DEGREE

______________ ____________ _________ ______________ ______________________
SOCIAL SECURITY# BIRTH DATE GENDER NPI# EMAIL ADDRESS

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

***REQUIRED INFORMATION FOR ALL APPLICANTS***

**SERVICE ADDRESS #1** (Where you see patients. If more than one, list the primary first.)

1. ______________________________ Phone: ______________________________

______________________________ Fax: ______________________________

______________________________ Contact Person: ______________________________

**PAY TO ADDRESS #1** (Where payment is sent when providing services at address #1.)

2. ______________________________ Phone: ______________________________

______________________________ Fax: ______________________________

______________________________ Group NPI#: ______________________________

Check payable to: ______________________________ Taxpayer ID#: ______________________________

**SERVICE ADDRESS #2**

3. ______________________________ Phone: ______________________________

______________________________ Fax: ______________________________

______________________________ Contact Person: ______________________________

**PAY TO ADDRESS #2** (Where payment is sent when providing services at address #2.)

4. ______________________________ Phone: ______________________________

______________________________ Fax: ______________________________

______________________________ Group NPI#: ______________________________

Check payable to: ______________________________ Taxpayer ID#: ______________________________

**REGULAR CORRESPONDENCE ADDRESS:**

☐ Same as Service address

☐ Same as Pay-To address

☐ Other: ______________________________

Email Address: ______________________________________________________

**CREDENTIALING CORRESPONDENCE ADDRESS:**

______________________________ Phone: ________________________

______________________________ Fax: __________________________

Contact Person: ____________________________________________________

Email Address: ______________________________________________________

**MISCELLANEOUS:**

**Do you provide <u>EPSDT</u> Services?** ☐ Y ☐ N

**Do you accept the following patients?**

| | | |
|---|---|---|
| Infants (3 months - 2 years) | ☐ Y | ☐ N |
| Children (2 years and above) | ☐ Y | ☐ N |
| Children (6 years and above) | ☐ Y | ☐ N |
| Children (12 years and above) | ☐ Y | ☐ N |

Other (please specify age): _________________________

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

| **Specialty** | **Certification No.** |
|---|---|
| 1. ______________________________ | ______________________________ |
| 2. ______________________________ | ______________________________ |

**Type of Facility or Office?** (For example: private office, clinic, 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): ____________________________________

____________________________________________________________________________

____________________________________________________________________________

**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. Services rendered to AlohaCare members prior to the completion of my credentialing and provider notification of acceptance into the AlohaCare provider network may not be honored for payment.**

| __________________________ | __________________________ | ____________________ |
|---|---|---|
| **Signature** | **Print Name** | **Date** |

# 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

Specialty: ______________________________

Telephone: ___________________________ Fax: ______________________________

Address:

_______________________________________

_______________________________________

_______________________________________

| ________________________ | ________________________ | ________________ |
|---|---|---|
| **Signature** | **Print Name** | **Date** |