



SPECIALIST 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).



SPECIALIST PROVIDER PROFILE FORM

PLEASE CHECK BOX IF PROVIDER IS A HOSPITALIST ONLY

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 EPSDT 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.

<u>Specialty</u>	<u>Certification No.</u>
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): _____

THIS QUESTION IS FOR PHYSICIANS ONLY:

Where do you have admitting privileges? (If you do not have admitting privileges, please complete the next page.) Please sign the last page so that your request will 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: _____
Address: _____
Privileges at: _____

2. Name: _____
Phone: _____ Fax: _____
Address: _____
Privileges at: _____

3. Name: _____
Phone: _____ Fax: _____
Address: _____
Privileges at: _____

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