

Contracting Application - Medical Providers

Use this application to apply for participation with the HWMG provider network, which is accessed by HMAA and self-funded clients. Please accurately and legibly complete **all** sections of this application, and mark non-applicable sections with "N/A." Incomplete applications or missing documents will delay your application process. For Providers with two or more practitioners, please complete the **Practitioner Registration** section of this application for **each** practitioner. Kindly retain a copy of the submitted application for your files.

Section 1: General Practice Information

Type 2 National Provider Identifier Number (NPI)	Federal Taxpayer Identification Number									
Business Name (as it appears on W-9)										
Practice Name (DBA) if different from Business Nam	me									
Type of Practice (check one only; if other, please sp Individual/Sole Proprietor Group F Durable Medical Equipment/Supplies Prov	Practice	Hospital Other (specify)	Facility (type: e	e.g., ASC etc.)						
Primary Practice Location										
Street Address		Cit	у	State	Zip Code					
Appointment Phone (for Provider Directory)	use only)	Email Address (for HWMG use only)								
Office Contact Person	Phone/Fax/Email									
Information above also applies to:										
Correspondence? Yes No, spec	cify contact info:									
■ Billing?	Billing? Yes No, specify contact info:									
Payments?	cify contact info:									
Make Checks Payable to										
Office Hours (Monday to Sunday)	Other Practice Information (if any)									
Additional Practice Location	1 - Please list all prad	ctice locations. If mo	ore than two, n	nake a copy of this	page.					
Street Address		Cit		State	Zip Code					
Appointment Phone (for Provider Directory) Office Fax (for HWMG to		use only)	Email Address (for HWMG use only)							
ffice Contact Person Title			Phone/Fax/Email							
Information above also applies to:										
Correspondence? Yes No, spec	cify contact info:									
■ Billing?	ecify contact info:									
Payments?										
Make Checks Payable to										
Office Hours (Monday to Sunday)	Other Practice Informa	ation (if any)								

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Practice Loca	tion Inf	ormation						
1. Does anyone spea		☐ Yes	☐ No					
If yes, specify lar								
2. Is the practice loc	ation(s):							
Shared with	<u></u>	☐ Yes	□No					
Accepting new patients?						☐ Yes	☐ No	
Equipped to meet Americans with Disabilities Act requirements?						☐ Yes	☐ No	
Section 2: I	Practit	ioner Registration						
		for each practitioner contract		ractice, and s	ubmit the follo	owing		
_		ugh https://proview.caqh.org/ application, attestation and a		m				
•		Hawaii State License						
	_	nforcement Administration (Dity insurance	EA) Controlled	Substances co	ertificate			
For assistance with	HWMG's	credentialing process, please	e feel free to co	ntact us. For a	assistance fro	m CAQI	Ⅎ.	
	able on th	eir website or you may contac						
Practitioner Ir	nformat	ion - If more than two, please I	make a copy of th	is page and co	mplete for each	1.		
Last Name		First Name	MI	Title/Degree	Date of Birth	☐ Male		
Individual NPI # (Type	dividual NPI # (Type 1) State Professional License ID			Has a CAQH ID #? ☐ Yes - enter ID:		□ No		
Specialties – list prima	Specialties – list primary specialty first (for Provider Directory)			Non-English languages spoken (if any)				
Additional Pra	actition	er Information						
Last Name		First Name	MI	Title/Degree	Date of Birth	☐ Ma		
Individual NPI # (Type	1)	State Professional License ID		Has a CAQH ID #?		□No		
Specialties – list primary specialty first (for Provider Directory)		Non-English I	Non-English languages spoken (if any)					
there are any change any misstatement or	es to the info	ided by me in my application is ormation provided, I will notify H on the application may result in the or network and understand an ag	WMG within thirty e withdrawal of the	y (30) days of a ne application f	ny change. I u rom considerat	nderstan tion. I ag	d that	
Name of Authorized Re	presentative	(print) Signature		_	Date			

Return this completed and signed application to **HWMG Provider Relations**. Contact information is shown above.

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