HWMG
HAWAII-WESTERN MANAGEMENT GROUP, INC.

Recredentialing Verification Form for Hospitals & Facilities

Participating providers are subject to the recredentialing process at least once every three years from the date initially credentialed by HWMG. Please complete all sections of this form for continued participation in the HWMG Provider Network. If more space is needed, attach additional sheets and reference the applicable section. Current copies of the following (where applicable) must be included:

- **Hawaii Health Care License**
- **Accreditation Certificates**
- **Proof of Liability Insurance Coverage**
- **Most Recent Government Agency On-Site Survey**

When you have completed and signed the form, please send it with the supporting documentation to:

HWMG Credentialing Department
220 South King Street, Suite 1200
Honolulu, HI 96813

Phone (808) 791-7518 | Toll-Free (800) 621-6998 ext. 306
Fax (808) 535-8314
Email Credentialing@hwmg.org

Provider Information

Hospital/Facility Name	NPI
Federal Taxpayer Identification Number(s)	Hawaii Health Care License Number(s)
Specialties to be listed in Provider Directory	

Credentialing Contact Information

Credentialing Contact Person & Job Title			Preferred Method of Contact ☐ Email ☐ Phone ☐ Mail ☐ Fax
Office Name	Phone Number	Fax Number	Email Address
Street Address		City	State Zip Code

Accreditation and Site Visits pertaining to the past 3 years

If accredited by a national accreditation organization that has been granted deeming authority by CMS, the site survey performed by the accrediting organization meets the Site Visit requirement.

Accredited?	Site Visit by a Government Agency (e.g., CMS or Dept of Health)?
☐ Does Not Apply ☐ Yes – expiration date: ☐ No	☐ Does Not Apply ☐ Yes – date of most recent survey: ☐ No

Disclosure Questions pertaining to the Past 3 Years

If you answer **Yes** to any of the questions below, attach a separate sheet providing an explanation for each occurrence and include the date of incident, details (including your role in the incident), subsequent events, your status, and the current status of any action taken.

1. Has the hospital/facility had any **liability claims or lawsuits** brought against it, including pending malpractice claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? ☐ Yes ☐ No
2. Has the hospital/facility's **license or registration** been investigated, terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board or any health-related agency organization, or is there a review pending? ☐ Yes ☐ No
3. Has the hospital/facility's **certificate or participation in any private, federal (e.g., Medicare, Medicaid) or state health insurance program** been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway? ☐ Yes ☐ No
4. Has the hospital/facility's **professional liability carrier** refused or cancelled its coverage or excluded it from performing any specific privileges or services, or has the hospital/facility operated without professional liability insurance? ☐ Yes ☐ No
5. Has the hospital/facility been denied **accreditation** by any accrediting body or had any **post-licensing onsite visit** by a government agency where deficiencies were identified? ☐ Yes ☐ No

Standard Authorization, Attestation, and Release

On behalf of the hospital/facility, I certify that all information provided by me in this application is accurate and true to the best of my knowledge and belief. If there are any changes to the information, I will notify HWMG within 30 days of any changes to the information. I authorize HWMG and its Agents to consult with any third party to verify these facts. I agree there shall be no liability on the part of, and no action for damages shall rise against HWMG, its Agents, or any entity providing information in good faith related to the verification of the information contained in this application. I understand and agree that any material misstatement in or omission from this form may result in the denial of my application or revocation of participation in the HWMG Provider Network. I understand and acknowledge that HWMG shall be solely responsible for all decisions concerning my network participation. I further acknowledge I have read and understand the foregoing Authorization and Release. A photocopy of this release shall be as effective as the original.

Name & Job Title of Authorized Representative (print) _____ Signature _____ Date _____

Upon receipt of this completed form and required attachments, the provider is considered to be recredentialed unless notified otherwise.