HWMG
HAWAII-WESTERN MANAGEMENT GROUP, INC.

Recredentialing Verification Form for Practitioners

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:

- **Proof of Liability Insurance Coverage**
- **State Controlled Substance or Federal DEA Certificate**
- **New or Renewed Specialty Board Certifications and Education/Training Certificates**

When you have completed and signed this form, please send it with 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

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

Provider Information

Last Name	First Name	MI	Suffix	Degree/Title

Other Name(s) Used	Last 4 digits of SSN	NPI Type 1 (Individual)	CAQH ID

Practitioner Email Address	Hawaii State Professional License Number(s)

Specialties to be listed in Provider Directory	Board Certified? ☐ Yes – expiration date: ☐ 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. Have you had any **professional liability claims or lawsuits** brought against you, including pending malpractice claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? ☐ Yes ☐ No
2. Are there any **other sanctions**, investigations, charges, indictments, misdemeanors, or other offense you were the subject of or were charged with, indicted, or found guilty of, or is there a review pending? ☐ Yes ☐ No
3. Has your **professional license or registration, or any applicable narcotic registrations** 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
4. Has your **clinical privileges, employment, hospital affiliations, and other affiliations** been updated, denied, terminated, stipulated, restricted, refused, limited, reprimanded, disciplined, suspended, revoked, relinquished, or not renewed by any health-related agency or organization, or is there a review pending? ☐ Yes ☐ No
5. Has your **certificate or participation in any private, federal, 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
6. Has your **professional liability carrier** refused or cancelled your coverage or excluded you from performing any specific privileges within your specialty, or have you practiced within your profession without professional liability insurance? ☐ Yes ☐ No
7. Do you currently have or have you previously had a **physical or mental health condition** (including substance abuse, chemical dependency, and/or illegal use of drugs) that could, without reasonable accommodation, reasonably impact your ability to provide appropriate care to patients and perform other essential job functions? ☐ Yes ☐ No

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Credentialing Contact Information

Provide the credentialing contact information for each unique tax identification number that you practice under. If we do not have current information on file, there could be a delay in providing your credentialing status, network updates, and other important information to your practice. You may also provide the most recent contact information by emailing us at Credentialing@hwmg.org.

Office Name		Tax ID # (TIN)	Preferred Method of Contact ☐ Email ☐ Phone ☐ Mail ☐ Fax
Credentialing Contact Person & Job Title	Phone Number	Fax Number	Email Address
Street Address	City	State	Zip Code

Office Name		Tax ID # (TIN)	Preferred Method of Contact ☐ Email ☐ Phone ☐ Mail ☐ Fax
Credentialing Contact Person & Job Title	Phone Number	Fax Number	Email Address
Street Address	City	State	Zip Code

Office Name		Tax ID # (TIN)	Preferred Method of Contact ☐ Email ☐ Phone ☐ Mail ☐ Fax
Credentialing Contact Person & Job Title	Phone Number	Fax Number	Email Address
Street Address	City	State	Zip Code

Office Name		Tax ID # (TIN)	Preferred Method of Contact ☐ Email ☐ Phone ☐ Mail ☐ Fax
Credentialing Contact Person & Job Title	Phone Number	Fax Number	Email Address
Street Address	City	State	Zip Code

Standard Authorization, Attestation, and Release

(PLEASE READ CAREFULLY BEFORE SIGNING)

In connection with this application for participation in the HWMG Provider Network, which is owned and operated by Hawaii-Western Management Group (HWMG), I understand and acknowledge it is my responsibility as the practitioner applicant to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by HWMG for Participation.

I further acknowledge I am responsible for knowing the contents of the applicable rules and regulations, and requirements of HWMG and its professional/clinical staff/network, and agree to be bound by them in the recredentialing process and if granted continued Participation. I agree to continue participation in the HWMG Provider Network and understand an application is not accepted until verified by HWMG.

1. **Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize HWMG and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualification for Participation and authorize such third parties to release such information to HWMG and/or its Agents.
2. **Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any health care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary information about any disciplinary action taken against me to HWMG and/or its Agents, and as otherwise may be required by law. I hereby further authorize HWMG to release Disciplinary information about any disciplinary action taken against me to its participating entities at which I have Participation, and as otherwise may be required by law. As used herein, Disciplinary Information means information concerning (i) any action taken by such health care organization, their administrators or their clinical or other committees to revoke, deny, suspend, restrict or condition my Participation or impose a corrective action plan; (ii) any other disciplinary actions involving me including but not limited to discipline in the employment context; or (iii) my registration prior to the conclusion of any disciplinary proceeding or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.
3. **Release from Liability.** I hereby further release from liability HWMG and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, clinical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunity provided by law for peer review activities.

I understand and agree that HWMG may communicate with me via e-mail over the internet regarding my application for credentialing. I understand that unencrypted, unauthorized Internet e-mail is inherently insecure. I further understand that Internet messages may be corrupted or incomplete, or may incorrectly identify the sender.

I understand and agree this Authorization and Release is irrevocable for any period during which I am participating with HWMG. I agree to execute consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide consent may be grounds for termination or discipline by HWMG in accordance with the applicable bylaws, rules and regulation, and requirements of HWMG.

I acknowledge that the investigation of information in this application and the release and exchange of Disciplinary Information by HWMG and its agents are done to achieve, maintain and improve quality patient care.

I certify that all information provided by me in this application is true, correct, and complete to the best of my knowledge and belief. If there are any changes to the information, I will notify HWMG within thirty (30) days of any changes to the information.

I understand and agree that any material misstatement in or omission from this application may result in the withdrawal of the application from consideration and constitute grounds for denial or revocation of Participation. I understand and acknowledge that HWMG shall be solely responsible for all decisions concerning the granting of Participation.

I further acknowledge I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization, Attestation, and Release shall be as effective as the original.

Name of Practitioner (print)	Signature	Date