HWMG
HAWAII-WESTERN MANAGEMENT GROUP, INC.

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ProviderRelations@hwmg.org

Contracting Application - Dental 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 name listed above	
Type of Practice (check one only; if other, please specify) ☐ Individual/Sole Proprietor ☐ Corporation ☐ Partnership ☐ Group Practice ☐ Other (please specify)_____	

Primary Practice Location

Street Address	City	State	Zip Code
Appointment Phone (for Provider Directory)	Office Fax (for HWMG use only)	Email Address (for HWMG use only)	
Office Contact Person	Title	Phone/Fax/Email	
Information above also applies to: • Correspondence? ☐ Yes ☐ No, specify contact info: • Billing? ☐ Yes ☐ No, specify contact info: • Payments? ☐ Yes ☐ No, specify contact info:			
Make Checks Payable to			
Office Hours (Monday to Sunday)	Other Practice Information (if any)		

Additional Practice Location - *Please list all practice locations. If more than two, make a copy of this page.*

Street Address	City	State	Zip Code
Appointment Phone (for Provider Directory)	Office Fax (for HWMG use only)	Email Address (for HWMG use only)	
Office Contact Person	Title	Phone/Fax/Email	
Information above also applies to: • Correspondence? ☐ Yes ☐ No, specify contact info: • Billing? ☐ Yes ☐ No, specify contact info: • Payments? ☐ Yes ☐ No, specify contact info:			
Make Checks Payable to			
Office Hours (Monday to Sunday)	Other Practice Information (if any)		

Practice Location Information

1. Does anyone speak any languages other than English to help non-English speaking patients? ☑ Yes ☑ No

   If yes, specify language(s):_____

2. Is the practice location(s):
   - Shared with other providers? If Yes, indicate provider name(s):_____ ☑ Yes ☑ No

     _____
   - Accepting new patients? ☑ Yes ☑ No
   - Equipped to meet Americans with Disabilities Act requirements? ☑ Yes ☑ No

Section 2: Practitioner Registration

Please complete this section for each practitioner contracted under your practice, **and** submit the following credentialing documents through CAQH ProView at https://proview.caqh.org/Login.

- Signed credentialing application, attestation and authorization form
- Current, unrestricted Hawaii State License
- Proof of U.S. Drug Enforcement Administration (DEA) Controlled Substances certificate
- Proof of current liability insurance

For assistance with HWMG's credentialing process, please feel free to contact us. For assistance from CAQH, resources are available on their website or you may contact their Provider Help Desk toll-free at (888) 599-1771 or providerhelp@proview.caqh.org.

Practitioner Information - *If more than two, please make a copy of this page and complete for each.*

Last Name	First Name	MI	Title/Degree	Date of Birth	☐ Male ☐ Female

Individual NPI # (Type 1)	State Professional License ID	Has a CAQH ID #? ☐ Yes - enter ID: _____ ☐ No

Specialties – list primary specialty first (for Provider Directory)	Non-English languages spoken (if any)

Certified to provide IV or general anesthesia? If yes, please submit a copy of your certificate through CAQH ProView. ☐ Yes ☐ No

Additional Practitioner Information

Last Name	First Name	MI	Title/Degree	Date of Birth	☐ Male ☐ Female

Individual NPI # (Type 1)	State Professional License ID	Has a CAQH ID #? ☐ Yes - enter ID: _____ ☐ No

Specialties – list primary specialty first (for Provider Directory)	Non-English languages spoken (if any)

Certified to provide IV or general anesthesia? If yes, please submit a copy of your certificate through CAQH ProView. ☐ Yes ☐ No

I certify that all information provided by me in my application is accurate and true to the best of my knowledge and belief. If there are any changes to the information provided, I will notify HWMG within thirty (30) days of any change. I understand that any misstatement or omission in the application may result in the withdrawal of the application from consideration. I agree to participate in the HWMG provider network and understand an agreement is not effective until accepted by HWMG.

_____ _____ _____

Name of Authorized Representative (print) Signature Date

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