HWMG
HAWAII-WESTERN MANAGEMENT GROUP, INC.

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ProviderRelations@hwmg.org

Provider Add, Delete or Change Form

Use this form to add, delete or change information to an existing provider. If requesting a TIN change, attach a Form W-9.

Request Type ☐ **Add** ***(see requirements below)*** ☐ **Delete** ☐ **Change**	**Effective Date** (mm/dd/yy)	**Tax ID #** (pay to)

Practitioner Information (Indicate **NEW** information only)

If **adding** a practitioner to an existing provider record, you must also submit a credentialing application with supporting documents (e.g., license, board certification) through CAQH ProView at https://proview.caqh.org/Login. For assistance with HWMG's credentialing process, please feel free to contact us. You may also visit the CAQH website or contact their Provider Help Desk toll-free at (888) 599-1771 or providerhelp@proview.caqh.org.

Last Name	First Name	MI	Title/Degree	Date of Birth	☐ Male ☐ Female
Individual NPI #	State Professional License #	Has a CAQH ID #? ☐ Yes - ID:_____ ☐ No		Tax ID # (TIN) – also submit W-9	
Specialties – list primary specialty first (for Provider Directory)	Non-English languages spoken (if any)	Other Practitioner Information (if any)			

Practice Information (Indicate **NEW** information only)

All practice locations must be listed when adding a practitioner. For multiple locations, please submit a form for each.

Street	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	

The information above applies to:

- Practice location? ☐ Yes ☐ No, specify contact info:
- Correspondence? ☐ Yes ☐ No, specify contact info:
- Billing? ☐ Yes ☐ No, specify contact info:

  Information applies to dates of service: ☐ Before **and** after the effective date above (e.g., all dates of service) ☐ Only on and after the effective date above
- Payments? ☐ Yes ☐ No, specify contact info:

  Information applies to dates of service: ☐ Before **and** after the effective date above (e.g., all dates of service) ☐ Only on and after the effective date above

Make Checks Payable to

Office Hours (Monday to Sunday)

I certify that all information provided by me on this form is true, correct, and complete. If there are any changes to the information, I will notify HWMG within thirty (30) days of the change.

Name (print) _____ Signature _____ Date _____

Please return this completed and signed form to **HWMG Provider Relations**.
Contact information is shown above.