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 the form, please send it with the supporting documentation to:

HWMG Credentialing Department
737 Bishop Street, Suite 1200
Honolulu, HI 96813

Phone (808) 791-7518 | Toll-Free (800) 621-6998 ext. 518
Fax (808) 535-8318
Email Credentialing@hwmg.org

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

Federal Taxpayer Identification Number(s)	Hawaii State Professional License Number(s)

Specialties to be listed in Provider Directory	Board Certified? ☐ Yes – expiration date: ☐ No

Credentialing Contact Information

Credentialing Contact Person & Job Title (if different from above)	Preferred Method of Contact ☐ Email ☐ Phone ☐ Mail ☐ Fax

Office Name	Phone Number	Fax Number	Email Address

Street Address	City	State	Zip Code

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

Standard Authorization, Attestation, and Release

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 of Practitioner (print) _____ Signature _____ Date _____

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