HWMG
HAWAII-WESTERN MANAGEMENT GROUP, INC.

Credentialing Application for Hospitals and Facilities

Instructions

1. Please accurately and legibly complete **all** sections of this Credentialing Application, and mark non-applicable fields with "**N/A**". If an entire section does not apply to you, simply check the box at the top of the section marked "**Does not apply**."
2. Complete each section in its entirety. If more space is needed, please attach additional sheets and reference the question being answered. Incomplete applications or missing documents will delay your application review.
3. Sign and date the *Authorization, Attestation, and Release* on page 4 of this application.
4. Kindly retain a copy of the submitted application for your files. Because certain information you provide will need to be verified, please allow up to sixty (60) days for processing. You will be notified in writing of the outcome.
5. When you have completed and signed the Credentialing Application, please send it with all required documents 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

Hospital/Facility Information

Type of Practice *(A separate application is required for each provider type and/or each practice location.)*

☐ Ambulatory Surgical Center *(Free-standing only)* ☐ Home Health Agency ☐ Skilled Nursing Facility *(Nursing home)*
☐ Durable Medical Equipment ☐ Hospital *(All types)* ☐ Other: _____

Facility Information

Hospital/Facility Name		
Federal Taxpayer ID #	Year Operation Began	Health System Affiliation (if any)
Main Address	City	State Zip Code
Phone Number	Fax Number	Email Address

Credentialing Contact Information

Credentialing Contact Person & Job Title		Preferred Method of Contact ☐ Email ☐ Phone ☐ Mail ☐ Fax	
Office Name (if different from above)	Phone Number	Fax Number	Email Address
Street Address (if different from above)		City	State Zip Code

Health Care License

List ALL (past, present, and pending) professional licenses.

State	License Number	Date Issued	Valid Through
State	License Number	Date Issued	Valid Through
State	License Number	Date Issued	Valid Through

General and Professional Liability Insurance Coverage

From (mm/dd/yy) To	Insurance Carrier Name		
Address	City	State	Zip Code
Policyholder Name		Policy Number	
Expiration Date	Amount of Coverage per Occurrence	Aggregate	

Accreditation

☐ **Does Not Apply**

Currently Accredited by *(at least one box must be checked):*

☐ AAAASF ☐ AAAHC ☐ ACHC ☐ AOA ☐ CARF ☐ CCAC ☐ CHAP

☐ JCAHO ☐ NCQA ☐ NIAHO ☐ URAC ☐ Other: _____

Date of Initial Accreditation	Date of Last Survey	Has the accreditation organization been granted deeming authority* by CMS for this provider type? ☐ Yes ☐ No

Has this hospital/facility ever been denied accreditation by any accrediting body?

☐ Yes; please provide date and details: _____

☐ No

*** 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 (refer to next Section).**

Site Visit Requirement

☐ **Does Not Apply**

Attach a copy of most recent on-site survey with the Corrective Action Plan if citations were issued; OR attach cover letter from state agency stating facility is in substantial compliance.

1. Has the hospital/facility had a post-licensing onsite visit by a government agency (e.g., CMS or Department of Health) within the past 36 months?

   ☐ Yes; Date of most recent on-site survey: _____

   ☐ No *(Note: Health plan on-site visit will be required to complete credentialing.)*

2. Were any deficiencies identified in the last full survey? ☐ Yes ☐ No

   - If YES, have all deficiencies been corrected?

     ☐ Yes; provide evidence of State acceptance with the hospital/facility's Corrective Action Plan

     ☐ No; provide explanation and the hospital/facility's plan to correct all deficiencies.

Physician Credentialing

☐ **Does Not Apply**

1. **Employed Physicians.** Does the hospital/facility verify for each Employed Physician under your practice, the credentials necessary to perform health care services? ☐ Yes ☐ No

   - If YES, please indicate how the hospital/facility conducts the credentialing process for each Employed Physician:

     ☐ Perform internally. ☐ Outsource/delegate procedures to _____.
     (Name of Company)

     ☐ Other, please specify: _____

   - If NO, please explain: _____

2. **Non-Employed, Affiliated Physicians.** Does the hospital/facility verify for each Non-Employed, Affiliated Physician under your practice, the credentials necessary to perform health care services at the hospital/facility? ☐ Yes ☐ No

   - If YES, please indicate how the hospital/facility conducts the credentialing process for each Employed Physician:

     ☐ Perform internally. ☐ Outsource/delegate procedures to _____.
     (Name of Company)

     ☐ Other, please specify: _____

   - If NO, please explain: _____

Delegation of Credentialing Functions

☐ **Does Not Apply**

1. Is the hospital/facility willing to perform credentialing functions on behalf of HWMG in accordance with its credentialing requirements and URAC accreditation standards? ☐ Yes ☐ No
   - If YES, please indicate which Physicians will be credentialed by hospital/facility on behalf of HWMG.

     ☐ Employed Physicians ☐ Non-Employed, Affiliated Physicians

Disclosure Questions

If you answer **Yes** to any of the Disclosure Questions below, please attach a separate sheet providing an explanation for each occurrence and include the date of incident, details (including the hospital/facility's role in the incident), subsequent events, the hospital/facility's status, and the current status of any action taken.

Licensure and Registration

1. Has the hospital/facility's **license or registration** ever been 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
2. Has the hospital/facility's **license or registration** ever been investigated or is it currently being investigated, and if so, what were the results? ☐ Yes ☐ No

Medicare, Medicaid or other Governmental Program Participation

3. Has the hospital/facility's certificate or participation in any private, Federal (e.g. Medicare, Medicaid) or state health insurance program ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway? ☐ Yes ☐ No

Liability Insurance

4. Has the hospital/facility's **professional liability carrier** ever refused, canceled, or refused renewal of the hospital/facility's coverage or excluded specific procedures or services from its coverage? ☐ Yes ☐ No
5. Is the hospital/facility currently, or has it within the last five years been involved in a **malpractice** suit or other suit or claim in which the care and treatment of a patient was at issue, including pending or dismissed cases or claims settled before or during trial, or settled to avoid a lawsuit? ☐ Yes ☐ No

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 the hospital/facility's responsibility to provide sufficient information upon which a proper evaluation can be undertaken of the hospital/facility's current licensure, ethics and any other criteria adopted by HWMG for Participation.

On behalf of the hospital/facility, I further acknowledge the hospital/facility is responsible for knowing the contents of the applicable rules and regulations, and requirements of HWMG and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation. I agree to have the hospital/facility participate in the HWMG Provider Network and understand an agreement is not effective until accepted 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 the hospital/facility's professional qualifications, credentials, ethics, or any other matter reasonably having a bearing on the hospital/facility's 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 the hospital/facility has applied for, currently have or had Participation to release Disciplinary information about any disciplinary action taken against the hospital/facility 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 the hospital/facility to its participating entities at which the hospital/facility has 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 medical or other committees to revoke, deny, suspend, restrict or condition the hospital/facility's Participation or impose a corrective action plan; (ii) any other disciplinary actions involving the hospital/facility including but not limited to discipline in the employment context; or (iii) the hospital/facility's registration prior to the conclusion of any disciplinary proceeding or prior to the commencement of formal charges but after the hospital/facility has 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, medical 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 the hospital/facility is an applicant for Participation 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 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 Authorized Representative (print)	Signature	Date
Job Title	Hospital/Facility Name	

Evidence of Credentials Checklist

A copy of the following documents (where applicable**) must be included** with your Application. All evidence must demonstrate current or active status, so please check the expiration dates, if any. Expired information or those with expiration dates within 30 days of submission will not be accepted and your application will be returned, which will delay your application review.

Please indicate the documents you have included with your application. If you have elected **not** to submit a particular document, please specify the reason.

Type of Document/Evidence	Check (✓) if Included	Reason for Omission
1. Health Care License(s) *(expiration not within 30 days of submission)*	☐	☐ Not Licensed ☐ Pending from Issuer ☐ Other: _____
2. Proof of Liability Insurance Coverage *(expiration not within 30 days of submission)*	☐	☐ Not Covered ☐ Pending from Issuer ☐ Other: _____
3. Accreditation Certificate(s) *(expiration not within 30 days of submission)*	☐	☐ Not Accredited ☐ Pending from Issuer ☐ Other: _____
4. Most Recent Government Agency On-Site Survey *(including Corrective Action Plan if citations were issued)*	☐	☐ No Issued Citations to Report ☐ Other: _____
5. Written documentation detailing history of professional liability claims, medical sanctions, or disciplinary actions	☐	☐ No History, Sanctions, or Actions to Report ☐ Other: _____
6. Standard Authorization, Attestation, and Release *(see previous page, signed and dated)*	☐	☐ Please specify: _____ ☐ Other: _____
7. Provider Credentialing & Contracting Application *(fully completed, signed & dated)*	☐	☐ Please specify: _____ _____