PROVIDER CREDENTIALING APPLICATION

Thank you for your interest in contracting with AlohaCare to serve our AlohaCare Quest Integration and AlohaCare Advantage (HMO SNP) members. In order to begin the process of joining AlohaCare's Provider Network, we ask that you complete the attached Provider Credentialing Application.

Please return your completed application with all required documents requested below:

- Copy of current Hawaii State Professional License
- Copy of current Professional Liability Insurance

  Note: Minimum requirements for Professional Liability Insurance is $1 million per claim with $3 million in the annual aggregate.
- Copy of current Hawaii State Controlled Substance Certificate (if applicable)
- Copy of current Federal DEA Certificate (if applicable)
- Copy of CV or Resume
- Completed W-9 Form
- Completed Disclosure Information Form

Fax or mail the completed application, with the required documents to:

Fax: (808) 973-0203

Address: AlohaCare
Attn: Provider Services
1357 Kapiolani Blvd Ste 1250
Honolulu HI 96814

Once we have received the necessary paperwork, we will initiate the formal credentialing and contracting process.

Providers must be credentialed by AlohaCare prior to rendering care or services to AlohaCare members. Services rendered to AlohaCare members prior to the completion of credentialing and provider notification of acceptance into the AlohaCare provider network will not be honored for payment.

Please contact our Provider Services Department at 973-1650 (Oahu) or 1-800-434-1002 (Neighbor Islands) if you have any questions regarding these forms or instructions.

PROVIDER CREDENTIALING APPLICATION

AlohaCare
For a healthy Hawaii.

IDENTIFICATION AND DEMOGRAPHICS (please PRINT in **BLACK** ink)

Provider Classification: ☐ Primary Care Physician ☐ Specialist Physician ☐ Hospitalist

Specialty: _____

Provider Type: ☐ MD ☐ DO ☐ DPM ☐ DC ☐ OD ☐ DDS ☐ DMD ☐ PHD ☐ PSYD

☐ Other:

Legal Name

Title: _____ Last Name: _____

First Name: _____ Middle: _____

Suffix (e.g., Jr): _____

Other Names (please check one): ☐ Previously Known As ☐ Also Known As ☐ Maiden

Last Name: _____ Suffix (e.g., Jr): _____

First Name: _____ Middle: _____

Title: _____

Provider Info

Date of Birth: _____ Social Security Number: _____ Gender: ☐ Male ☐ Female

Contact Phone No. (Optional): _____ Cell Phone No. (Optional): _____

Individual NPI: _____

Email Address: _____

Website: _____

Medicaid Number: _____ (Medicaid) State: _____

Medicare PTAN: OT, PT, SP, MNT – Submit Medicare confirmation letter if you will be participating in AlohaCare's Medicare plan

Medicare Status:

☐ Participating ☐ Nonparticipating ☐ Enrolled ☐ Not Enrolled ☐ Opt Out

In Process for:

☐ Participating ☐ Nonparticipating

Please select the ALOHACARE programs you would like to participate in below.

☐ Medicare Advantage (HMO SNP) ☐ QUEST Integration

Max number of members: Max number of members:

Have you completed Cultural Competency Training? ☐ Yes ☐ No

Do you provide EPSDT Services?

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program for children up to age 21 which emphasizes the importance of prevention through early screening for medical, dental and behavioral health conditions and timely treatment of conditions that are detected.

☐ Yes ☐ No

Do you have age restrictions (If yes, please describe)? ☐ Yes ☐ No Please Describe:

FOR ALOHCARE USE ONLY Type of application: ☐ Initial Credentialing ☐ Re-Credentialing Next Review Date: _____

OFFICE INFORMATION/LOCATION OF PRACTICE

Note: If you have additional locations, please make copies of this page as needed

Please select all that apply for the following location:
☐ Primary ☐ Additional ☐ Billing ☐ Home ☐ Mailing ☐ Credentialing ☐ Provider Directory

Office Practice Name: Date Joined:

Address

Street: City:

State: Zip Code:

Office Information

Accepting New Patients: ☐ Yes ☐ No

Phone/Appointment Phone: E-mail:

Contact Name:

Contact Phone: Office Fax: Referral Fax:

Acceptable to send confidential information? ☐ Yes ☐ No Credentialing Contact:

Clinical Lab Inspection Approval (CLIA) Number (if applicable):

Physician Assistants, please provide the name of your supervising physician:

Entity Name:

Clinic or Group Name:

Group NPI Number: Federal Tax ID Number:

Is this practice compliant with the Americans with Disabilities Act (ADA) standards? ☐ Yes ☐ No

Does this practice provide TeleHealth Services? ☐ Yes ☐ No

If yes, does your practice have a secure and HIPAA compliant platform to perform these services? ☐ Yes ☐ No

Languages Spoken (Please check all that apply):

☐ Cantonese	☐ Marshallese	☐ Spanish
☐ Mandarin	☐ Hawaiian	☐ Thai
☐ Ilocano	☐ Japanese	☐ Tongan
☐ Tagalog	☐ Korean	☐ Vietnamese
☐ Chuukese	☐ Samoan	☐ Sign Language

Office Hours

Mon Open	Tue Open	Wed Open	Thu Open	Fri Open	Sat Open	Sun Open

Mon Close	Tue Close	Wed Close	Thu Close	Fri Close	Sat Close	Sun Close

FOR ALOHCARE USE ONLY Type of application: ☐ Initial Credentialing ☐ Re-Credentialing Next Review Date: _____

Additional Payment

Payment Checks Should be Made Out to:

☐ Provider ☐ Provider's Office Practice Name ☐ Clinic or Group ☐ Other (Specify): _____

Mail Payment Check to: ☐ Payment Address ☐ Office

Is the mailing address for all locations the same? ☐ Yes ☐ No

State Licensure

Include all licenses current or held in last five years

Name of State Board Issued by: _____ State: _____

License Number: _____ License Type: _____

Exp. Date: _____ First Issued: _____ ☐ Active License ☐ Inactive License

Name of State Board Issued by: _____ State: _____

License Number: _____ License Type: _____

Exp. Date: _____ First Issued: _____ ☐ Active License ☐ Inactive License

Name of State Board Issued by: _____ State: _____

License Number: _____ License Type: _____

Exp. Date: _____ First Issued: _____ ☐ Active License ☐ Inactive License

Specialty/Board Certification

List any certification received from any nationally recognized specialty certification boards.

Primary Specialty: _____

☐ Outpatient ☐ Inpatient

Board Certified? ☐ Yes ☐ No If no, Eligible to take Exam? ☐ Yes ☐ No If yes, planning to take exam? ☐ Yes ☐ No

(If applicable) Name of certifying board: _____

Certificate #: _____ Expiration Date: _____ Original Effective Date: _____ Re-certification Date: _____

Other Specialty: _____

☐ Outpatient ☐ Inpatient

Board Certified? ☐ Yes ☐ No If no, Eligible to take Exam? ☐ Yes ☐ No If yes, planning to take exam? ☐ Yes ☐ No

(If applicable) Name of certifying board: _____

Certificate #: _____ Expiration Date: _____ Original Effective Date: _____ Re-certification Date: _____

Other Specialty: _____

☐ Outpatient ☐ Inpatient

Board Certified? ☐ Yes ☐ No If no, Eligible to take Exam? ☐ Yes ☐ No If yes, planning to take exam? ☐ Yes ☐ No

(If applicable) Name of certifying board: _____

Certificate #: _____ Expiration Date: _____ Original Effective Date: _____ Re-certification Date: _____

☐ Please check if there are additional Board Certifications and include a copy in attachments

FOR ALOHCARE USE ONLY Type of application: ☐ Initial Credentialing ☐ Re-Credentialing Next Review Date: _____

Professional Education and Training

ECFMG Number (☐ if applicable):

Name of Medical/Professional School: _____

Address of Medical/Professional School: _____

Degrees Earned: _____ From(mm/yy): _____ Through(mm/yy): _____ Date of Completion: _____

Specialty: _____ Name of Medical/Professional School: _____

Address of Medical/Professional School: _____

☐ Internship ☐ Residency ☐ Fellowship From(mm/yy): _____ Through(mm/yy): _____ Date of Completion: _____

Specialty: _____ Name of Medical/Professional School: _____

Address of Medical/Professional School: _____

☐ Internship ☐ Residency ☐ Fellowship From(mm/yy): _____ Through(mm/yy): _____ Date of Completion: _____

Specialty: _____ Name of Medical/Professional School: _____

Address of Medical/Professional School: _____

☐ Internship ☐ Residency ☐ Fellowship From(mm/yy): _____ Through(mm/yy): _____ Date of Completion: _____

Hospital Affiliations and Privileges

Primary Hospital Affiliation Name: _____

Address / City / State / Zip: _____

Initial Appointment Date: _____ Next Re-Appointment Date: _____

Staff Category: _____ Admitting Privileges?* ☐ Yes ☐ No

Primary Hospital Affiliation Name: _____

Address / City / State / Zip: _____

Initial Appointment Date: _____ Next Re-Appointment Date: _____

Staff Category: _____ Admitting Privileges?* ☐ Yes ☐ No

Primary Hospital Affiliation Name: _____

Address / City / State / Zip: _____

Initial Appointment Date: _____ Next Re-Appointment Date: _____

Staff Category: _____ Admitting Privileges?* ☐ Yes ☐ No

****If no admitting privileges**, you are required to have a written arrangement with another healthcare practitioner that has admitting privileges with an acute care hospital that is within the AlohaCare Network and on the island of service.*

Please list the physician's information below **AND** provide a copy of the written agreement.

Admitting Physician Name: _____ Name of Hospital: _____

Address / City / State / Zip: _____

Phone: _____ Fax: _____ Email: _____

☐ Please check if there are additional Hospital Affiliations and include a copy of attachments

FOR ALOHCARE USE ONLY Type of application: ☐ Initial Credentialing ☐ Re-Credentialing Next Review Date: _____

Work History

For Initial Credentialing, five (5) years of work history is required in MM/YYYY format. For re-credentialing the requirement is three (3) years. If attaching a CV in lieu of completing below, please include Month and Year of start and end date.

Office Practice Name: ______________________ From: __________ To: __________

Have you had a break in service for more than six months? If yes, please explain:

Office Practice Name: ______________________ From: __________ To: __________

Have you had a break in service for more than six months? If yes, please explain:

Office Practice Name: ______________________ From: __________ To: __________

Have you had a break in service for more than six months? If yes, please explain:

Controlled Substances Registration (if not applicable, leave this section blank.)

Hawaii Controlled Substance Certification (CSC)

CSC No: ______________________ Effective Date: __________ Expiration: __________

Restrictions: ______________________

Federal Drug Enforcement Association (DEA) Certificate – Must Have a Hawaii Certificate

DEA No: ______________________ Effective Date: __________ Expiration: __________

Restrictions: ______________________

Professional Liability Coverage Information

(Please list the names and complete addresses of each professional malpractice insurer, attach additional sheets if necessary)

Current Carrier Name: ______________________ Policy Number: ______________________

Address / City / State / Zip: ______________________

Effective Date: __________ Expiration Date: __________ Retroactive Date: __________

Amount Per Incident: __________ Aggregate Amount: __________ Umbrella Amount: __________

Exclusions or Limitations: ______________________

Current Carrier Name: ______________________ Policy Number: ______________________

Address / City / State / Zip: ______________________

Effective Date: __________ Expiration Date: __________ Retroactive Date: __________

Amount Per Incident: __________ Aggregate Amount: __________ Umbrella Amount: __________

Exclusions or Limitations: ______________________

Current Carrier Name: ______________________ Policy Number: ______________________

Address / City / State / Zip: ______________________

Effective Date: __________ Expiration Date: __________ Retroactive Date: __________

Amount Per Incident: __________ Aggregate Amount: __________ Umbrella Amount: __________

Exclusions or Limitations: ______________________

FOR ALOHCARE USE ONLY Type of application: ☐ Initial Credentialing ☐ Re-Credentialing Next Review Date: __________

Health Status		
Health status is defined as the physical and mental conditions of the applicant as they relate to the individual's ability to exercise those clinical privileges requested.		
a. Can you perform the functions of the privileges that you are requesting, and/or the contractual arrangement for which you are applying, with or without accommodations? If no, please explain:	☐ Yes	☐ No
b. Are you presently using illegal drugs?	☐ Yes	☐ No
c. Have you in the past five years used and/or been treated for substance abuse (i.e., drugs, prescription medications or alcohol)? If yes, please explain:	☐Yes	☐No

Restrictive Actions		
* If you answer "Yes" to any of the questions below, please attach an explanation of each occurrence to include the date, parties involved, and circumstances surrounding the situation, outcome, and any copies of court documents.		
a. Are you currently a named defendant to any pending malpractice claim or suit?	☐ Yes*	☐ No
b. Have you ever been a named defendant in any malpractice claim or suit where judgment was made against you or where you settled out of court with plaintiff?	☐ Yes*	☐ No
c. Is there any current or pending due-process action relating to denial, revocation, suspension, or restriction for any of your clinical privileges, appointment, membership, employment, and/or contractual arrangement at any health care organization?	☐ Yes*	☐ No
d. Have any of your applications for clinical privileges, appointment, membership, employment, and/or contractual arrangement at any health care organization ever been denied, revoked, suspended, restricted, limited, reduced, or terminated voluntarily or involuntarily?	☐ Yes*	☐ No
e. Have any of your clinical privileges, appointment, membership, employment, and/or contractual arrangement at any health care organization ever been subject to any type of monitoring that is not routinely applied to other practitioners of your specialty?	☐ Yes*	☐ No
f. Is there any current or pending due-process action relating to denial, revocation, suspension, or restriction for any of your professional licenses or applications for professional license in any jurisdiction?	☐ Yes*	☐ No
g. Have any of your professional licenses or applications for professional licenses ever been challenged, denied, revoked, suspended, restricted, limited, conditioned, or voluntarily or involuntarily relinquished?	☐ Yes*	☐ No
h. Does your current liability malpractice coverage exclude specific procedures?	☐ Yes*	☐ No
i. Have you been without malpractice coverage in the past five consecutive years?	☐ Yes*	☐ No
j. Has your professional liability insurance coverage ever been denied, suspended, restricted, limited, modified, canceled, or not renewed by the action of any insurance company?	☐ Yes*	☐ No
k. Have any of your controlled substance certificates or federal drug enforcement agency certificate ever been challenged, denied, revoked, suspended, restricted, limited, conditioned, or voluntarily or involuntarily relinquished?	☐ Yes*	☐ No
l. Are there any current or pending investigations or actions being taken against you, or have there ever been any restrictive actions taken against you by the Medicare program, Medicaid program, Regulated Industries Complaints Office, Medical Inquiry and Conciliation Panel (MICP), the Hawaii Department of Commerce and Consumer Affairs, and/or the Hawaii Board of Medical Examiners?	☐ Yes*	☐ No
m. Has your membership to local, state, or national medical societies ever been placed on probation, revoked, suspended, or terminated?	☐ Yes*	☐ No
n. Have you ever been convicted of a crime, pled guilty or "no contest" to a crime (other than a traffic offense), or are you currently under indictment for an alleged crime?	☐ Yes*	☐ No
o. Do you currently employ anyone who has been excluded from the Medicare or Medicaid program?	☐ Yes*	☐ No
p. Has there ever been any disciplinary action, suspension, probation, formal reprimand or request to voluntarily or involuntarily resign during your education, internship, residency, fellowship, preceptorship, or additional applicable training?	☐ Yes*	☐ No

FOR ALOHCARE USE ONLY Type of application: ☐ Initial Credentialing ☐ Re-Credentialing Next Review Date: _____

Accessibility

Physicians, provide what type of arrangements your practice has to ensure continuous 24-hour accessibility to medical services (i.e., emergency and vacation coverage). Please provide the name, address, and telephone number of the physician(s) covering for you.

Attestation

I hereby affirm that the above information is complete, accurate and true, to the best of my information, knowledge, and belief.

Signature

Date

Printed or Stamped Name

Please return application and attachments to:

AlohaCare
Attn: Provider Services
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Phone (808) 973-1650 on Oahu
1 (800) 434-1002 toll-free on the Neighbor Islands

Fax: (808) 973-0203 on Oahu

FOR ALOHCARE USE ONLY Type of application: ☐ Initial Credentialing ☐ Re-Credentialing Next Review Date: _____

CONSENT & RELEASE FORM

I HEREBY AUTHORIZE representatives and agents of AlohaCare, to request and obtain information regarding my professional credentials and qualifications from all educational facilities, hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, federal and state regulatory and licensing agencies, professional liability insurance carriers, other professional monitoring entities, professional associations, managed health care plans, other physicians, present and past employers and federal and state agencies for criminal background checks (hereafter collectively referred to as "persons or entities"). The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter applicable to the credentialing procedure. I RELEASE AND AGREE to hold harmless AlohaCare and its respective officers, directors, representatives, employees and agents from any and all liability for any damages, costs and expenses which may result from their acts in obtaining and verifying information during the credentialing process.

I HEREBY AUTHORIZE the education facilities, the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, federal and state regulatory and licensing agencies, professional liability insurance carriers, other professional monitoring entities, professional associations, managed health care plans, other physicians, present and past employers and federal and state agencies for criminal background checks, to release information requested by AlohaCare, including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure.

If applicable, I HEREBY AUTHORIZE the Physician Recovery Network or applicable recovery program to release to AlohaCare information regarding my health status and participation status in any treatment program(s).

I HEREBY FURTHER RELEASE AND AGREE to hold harmless all such persons or entities referenced above, their representatives, employees, and agents from any and all liability for any damages which may result from providing this information.

I AGREE that the photocopy, facsimile, and/or electronic image of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original, and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I UNDERSTAND that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is a cause for automatic and immediate rejection of this application by AlohaCare and may result in denial of my application or termination of my participation in the AlohaCare Network. I further understand that any representation, misstatement or omission from this application, if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of those privileges.

I UNDERSTAND AND AGREE that I, as an applicant, have the burden of producing adequate information to demonstrate to the satisfaction of AlohaCare my professional qualifications, clinical competence, moral character and ethical qualifications and for resolving doubts thereto.

I AGREE to use my best efforts to inform AlohaCare in writing within 15 calendar days if there is any change in the information provided or the answers to questions on the application as a result of developments subsequent to my signing this application.

I WARRANT that I have the authority to sign this application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity.

I AGREE that submission of the application does not constitute approval or acceptance as a participating provider.

If I am accepted for participation, I CONSENT to the inspection of my patient records for AlohaCare members as necessary for peer review and utilization review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual.

I UNDERSTAND that I have the right to review and correct erroneous information obtained by AlohaCare to evaluate my credentialing application. This includes information obtained from primary source (e.g., malpractice insurance carriers, state licensing boards, National Practitioner Data Bank). The review must take place within 6 months of this application. Any corrections must be made in writing within 30 days of the review. This does not require AlohaCare to allow a provider to review references or recommendations or other information that is peer-review protected.

I UNDERSTAND that if my application is rejected for reasons relating to my professional conduct or competence, AlohaCare may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

I REPRESENT that the information provided in or attached to this application is true, accurate and complete to the best of my information, knowledge, and belief.

AlohaCare does not discriminate on the basis of race, color, creed, national origin, ancestry, sex, including gender identity or expression, sexual orientation, religion, age, health status, income status, or physical or mental disability.

Your signature is required to complete this application. Stamped signatures are not acceptable.

_____	_____	_____
Practitioner Name (Print)	*Practitioner Signature*	*Date*

FOR ALOHCARE USE ONLY Type of application: ☐ Initial Credentialing ☐ Re-Credentialing Next Review Date: _____

DISCLOSURE INFORMATION (DI)

AlohaCare
For a healthy Hawaii.

As required by the Affordable Care Act (42 CFR §455 Subpart B) and Hawaii Administrative Rules (§17-1736-20 & §17-1736-21) the following information must be submitted to AlohaCare prior to certificaiton or renewal as a provider under Medicaid. **For provider groups or sole proprietors, failure to provide accurate and complete disclosure information will render this application incomplete.** THIS FORM IS REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR §455.101, §455.105 and §455.106 and HAR §17-1736-19). Note: See the instructions of this form for definitions of underlined terms according to 42 CFR §455.101, §455.104, §455.105, and HAR §17-1736-19. ***All attachments must be labeled and reference to the question the attachment pertains.***

1	Entity Name that this DI pertains to:
2	Enter current NPI/Medicaid Provider number combination that this DI is in reference to, if applicable. NPI: _____ Provider number: _____ Provider number *(Enter only if you are not required to have a NPI/Taxonomy Code for billing purposes)*: _____ ☐ *Check here for Not Applicable (N/A)*
3	If there has been a change in ownership, change of tax ID number (FEIN), or change in Medicaid Provider Number for previously enrolled Hawaii Medicaid provider, enter the previous provider number(s) and their effective date(s): ☐ *Check here for N/A* Previous Medicaid Provider #: _____ Start Date: _____ End Date: _____
4	If you completed item #3, describe the relationship between the provider disclosing information on this form, and the following: (a) previous Medicaid owner (b) coporate boards of disclosing provider and previous Medicaid owner; i.e. board members and ownership or control interest (c) disenrollment circumstances. (Attach extra page if necessary.) a. _____ b. _____ c. _____
5	If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change. ☐ *Check here for N/A* Date: _____ Change: _____
6	If you anticipate filing for bankruptcy within the year, enter: ☐ *Check here for N/A* Anticipated date of filing: _____
7	If this facility is a subsidiary of a parent corporation, complete below. Corporate FEIN#: _____ Name: _____ Address: _____ City: _____ State: _____ Zip: _____

8	List name, date of birth, SSN#/FEIN#, and address of each person or entity that owns 5% or more direct or indirect ownership or controlling interest in the application provider. (Attach extra pages if necessary.) Complete item #9 with the officer's and board members' information fo the owning entities. ☐ *No owner has more than 5% of ownership* Name/Business Name: _____ SSN: _____ FEIN: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____ ***If a corporate entity is disclosed in items #8 above, all business location (s) of this corporate entity must be disclosed. Please attach a sheet to disclose this information.***
9	List officer's and board members' information of owning entities. (Attach extra sheet if necessary, listing same details below.) ☐ *Check here for N/A* Name (a): _____ Start Date: _____ Title: _____ SSN: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____ Name (b): _____ Start Date: _____ Title: _____ SSN: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____
10	If any individuals listed in items #8 and #9 are related to each other as spouse, parent, child or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.) ☐ *Check here for N/A* Name (a): _____ Relationship: _____ SSN: _____ FEIN: _____ Name (b): _____ Relationship: _____ SSN: _____ FEIN: _____
11	If this facility or organization employs a management company, please provide the following information: ☐ *Check here for N/A* Name: _____ Address: _____ City: _____ State: _____ Zip: _____
12	List the names of any other disclosing entity in which person(s) listed on this application have ownership of other Medicare/Medicaid facilities. ☐ *Check here for N/A* Name: _____ Provider #, if applicable: _____ Address: _____ City: _____ State: _____ Zip: _____

13	List the names and addresses of all other Hawaii Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of $25,000 or 5% of your total operating expense. (Attach extra page if necessary.) ☐ *Check here for N/A* Name: _____ Address: _____ City: _____ State: _____ Zip: _____
14	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year periods. (Attach extra page if necessary.) ☐ *Check here for N/A* Name: _____ Address: _____ City: _____ State: _____ Zip: _____
15	List the name, SSN, and address of any immediate family member who is authorized under Hawaii Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment. ☐ *Check here for N/A* Name (a): _____ Title: _____ SSN: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____ Name (b): _____ Title: _____ SSN: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____
16	List the names of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a Hawaii Medicaid provider number(s), please indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A* Name (a): _____ Hawaii Medicaid Provider Number(s), if applicable: _____ Name (b): _____ Hawaii Medicaid Provider Number(s), if applicable: _____

17	List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra pages if necessary) If individual or organization is associated with a Hawaii Medicaid provider number(s), indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A* Name (a): _____ Hawaii Medicaid Provider Number(s), if applicable: _____ Name (b): _____ Hawaii Medicaid Provider Number(s), if applicable: _____
18	List the name, title, FEIN/SSN, and business address of all managing employees below as defined in 42 CFR §455.101. (Attach extra page if necessary listing same details below.) ☐ *Check here for N/A* Name (a): _____ Start Date: _____ Title: _____ SSN: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____ Name (b): _____ Start Date: _____ Title: _____ SSN: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____
19	List the name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. (Attach extra page if necessary) ☐ *Check here for N/A* Name (a): _____ SSN: _____ FEIN: _____ Address: _____ City: _____ State: _____ Zip: _____ Name (b): _____ SSN: _____ FEIN: _____ Address: _____ City: _____ State: _____ Zip: _____
20	If you keep medical records on an electronic database, you hereby certify by your initials in the space provided that electronic records are confidential and patient privacy is protected. Every health care provider or organization, regardless of size, who creates or maintains individual protected health information in any form (written, oral, or electronic) for the purpose of treatment, payment, or operation is a covered entity and must comply with HIPAA Privacy and Security Rules. **Initials** _____

21	Contact Information – This information is used only for questions regarding the information on this form. Name: _____ Telephone: _____ E-mail address: _____
22	I certify that all the Information I have provided on this AlohaCare Disclosure of Ownership Form is accurate. Failure to provide accurate information could result in termination from the Medicaid program. Signature: _____ Date signed: _____ Printed name: _____ Title: _____
FOR ALOHACARE USE ONLY:	
23	Signature: _____ Date signed: _____ Printed name: _____ Title: _____

_____	_____	_____
EPLS/SAM:	OIG/HHS:	SSA Death Master File:

I/We hereby attest that the information contained in the Disclosure Statement is current, complete and accurate to the best of my knowledge. I/We understand that if I/we knowingly or willfully make or cause to make a false statement or representation on the statement, I/We may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate in the Medicaid Program.

Further, the Provider shall, upon discovery of any information required by federal and state regulations, immediately notify AlohaCare in writing of the information required to be provided.

_____ _____

Signature of Provider/Authorized Business Agent | Date signed

_____

Printed Name of Provider/Authorized Business Agent