AlohaCare
For a healthy Hawaii.

ADDRESS CHANGE
CLOSED LOCATION
ADDITIONAL LOCATION

Please fax completed form to:
Contracts & Credentialing Department
(808) 973-0203

NOTE: Changes will impact all lines of business for which you are contracted.

Provider Name: _____

Tax ID Number: _____ Individual National Provider Identifier (NPI): _____

Please complete the appropriate section(s) below.

ADDRESS CHANGE

I am changing the address of an existing practice location effective (mm/dd/yy): _____

BUSINESS LOCATION ADDRESS

Previous address: _____

New Address: _____

Will this be your primary location?

☐ Yes ☐ No, primary location is: _____

If you are a participating provider, check those boxes that are applicable to this location.

☐ List location in AlohaCare Doctor Finder and Provider Directory ☐ Accepting new members

Contact Phone Number: _____ Fax Number: _____

Email: _____ Office Hours: _____

Would you like notification or memos/confirmation letters via email? ☐ Yes ☐ No

MAILING ADDRESS

(Note: Our record system can accommodate only one mailing address per provider.)

New mailing address, if changing: _____

PAYMENT INFORMATION

Name of Clinic or Group Practice: _____

Federal ID Number of Clinic or Group: _____ Group NPI: _____

If you are affiliated with a clinic or group, please check status: ☐ Employed ☐ Contracted

Payment checks made out to: ☐ Self ☐ Clinic named above ☐ Other (Specify) _____

Mail check to: ☐ Business location address ☐ Mailing address indicated above

☐ Other (Specify) _____

OTHER INFORMATION

Languages spoken by - Provider: _____

Staff: _____

Access to interpreter services: ☐ Yes ☐ No Handicap accessibility: ☐ Yes ☐ No

Please indicate if you have a subcontract for duties under AlohaCare's contract: ☐ Yes ☐ No

If you are considering entering into a subcontractor agreement, please call Provider Services at (808) 973-1650 to discuss your obligations under the AlohaCare Provider Agreement.

CLOSED LOCATION

I no longer practice at the following location address:

_____

Forwarding address: _____

Last date services will be provided at this location (mm/dd/yy): _____

Reason for closure of this location: _____

ADDITIONAL LOCATION

I am adding a new practice location effective (mm/dd/yy): _____

BUSINESS LOCATION ADDRESS

Address: _____

Mailing Address: _____

Will this be your primary location?

☐ Yes ☐ No, primary location is: _____

If you are a participating provider, check those boxes that are applicable to this location.

☐ List location in AlohaCare Doctor Finder and Provider Directory ☐ Accepting new members

Contact Phone Number: _____ Fax Number: _____

Email: _____ Office Hours: _____

Would you like notification or memos/confirmation letters via email? ☐ Yes ☐ No

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Provider's Signature: _____ Date: _____