AlohaCare
Aloha is the difference

FACILITY & ANCILLARY PROVIDER PROFILE FORM

Thank you for your interest in contracting with AlohaCare to serve our AlohaCare QUEST, AlohaCare Advantage and/or AlohaCare Advantage Plus members. In order to begin the process of joining AlohaCare's Provider Network, we ask that you complete the attached AlohaCare Provider Profile.

Please complete the attached Provider Profile and return it to AlohaCare with the documents requested below:

- State License (if applicable)
- Copy of accreditation or certificate, along with accompanying report for levels of care to be provided
- Copy of accreditation corrective action plan (if applicable)
- Copy of Medicare approval/certificate (if providing services to Medicare members)
- 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.
- Completed W-9 Form
- Copy of CLIA Certificate (if applicable)

Fax or mail copies of the completed Provider Profile, with additional documents to:

Fax: (808) 973-0203

Address: AlohaCare
ATTN: Provider Services
1357 Kapiolani Blvd., Suite 1250
Honolulu, Hawaii 96814

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

FACILITY & ANCILLARY PROVIDER PROFILE FORM

ENTITY NAME

FED. ID# NPI # QUEST PROVIDER ID# MEDICARE ID#

Check the Program(s) you will participate with: ☐ QUEST ☐ Medicare (AlohaCare Advantage plans)

Claims will be submitted on: ☐ Form 1500 ☐ Form UB

REQUIRED INFORMATION FOR ALL INSTITUTIONAL FACILITIES

Acute:

FED. ID# NPI # QUEST PROVIDER ID# MEDICARE ID#

SNF:

FED. ID# NPI # QUEST PROVIDER ID# MEDICARE ID#

Swing:

FED. ID# NPI # QUEST PROVIDER ID# MEDICARE ID#

Home Health Agency:

FED. ID# NPI # QUEST PROVIDER ID# MEDICARE ID#

Do you have downstream contracted providers? ☐ Yes ☐ No ☐ Not Applicable

A downstream provider is a subcontractor with whom you have a separate agreement to provide services through your practice, group, or organization and who will provide services to AlohaCare members. This does not include your employees, only non-employee practitioners you have contracted with to provide services.

PRIMARY

SERVICE ADDRESS | CITY | STATE | ZIP CODE

PHONE | FAX | CONTACT PERSON

Check payable to: _____

PAY ADDRESS | CITY | STATE | ZIP CODE

PHONE | FAX | GROUP NPI ID# | TAXPAYER ID#

SECONDARY

If there are additional service addresses, please list on separate attachment.

SERVICE ADDRESS | CITY | STATE | ZIP CODE

PHONE | FAX | CONTACT PERSON

Check payable to: _____

PAY ADDRESS | CITY | STATE | ZIP CODE

PHONE | FAX | GROUP NPI ID# | TAXPAYER ID#

REGULAR CORRESPONDENCE ADDRESS:

☐ Same as Service address ☐ Same as Pay-To address

☐ Other _____

CREDENTIALING CORRESPONDENCE ADDRESS:

ADDRESS | CITY | STATE | ZIP CODE

PHONE | FAX | CONTACT PERSON | EMAIL ADDRESS

MISCELLANEOUS

Do you speak any foreign languages? If yes, please list language(s) spoken. (For reporting purposes.)

1. _____ 2. _____ 3. _____

Do you have a website? List Here: _____

Is your facility compliant with the Americans with Disabilities Act (ADA) Standards? ☐ Yes ☐ No

Have you completed a cultural competency training? ☐ Yes ☐ No

AGREEMENT

I hereby affirm that the Provider or Facility is eligible to participate in state and federally funded programs and that I will notify AlohaCare in the event that I or any individual covered under my (or the group) contract becomes debarred, suspended, or otherwise excluded from participating in state and federally funded programs. The information and/or documentation provided in this form is correct, complete and current to the best of my knowledge. I understand that I must be credentialed by AlohaCare prior to rendering care or services to AlohaCare members. I understand services rendered to AlohaCare members prior to the completion of my credentialing and provider notification of acceptance into the AlohaCare provider network will not be honored for payment.

PROVIDER/AUTHORIZED FACILITY REP. SIGNATURE | PRINT NAME | 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): _____ Title: _____ SSN: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____ Name (b): _____ 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): _____ Title: _____ SSN: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____ Name (b): _____ 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