An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA Provider Application Form For Business/Facility

PLEASE RETURN THIS CHECKLIST WITH YOUR APPLICATION
Use this checklist to make sure you have all of the documents required to complete your application. Before sending us your application packet, confirm that you've included eveything on this checklist. **We can't begin this enrollment process until we receive all required forms and documentation.**

REQUIRED FORMS – Submit one copy of each form, all with original signatures

- ☐ **HMSA Provider Application Form For Business/Facility**
- ☐ **If applying to be participating with HMSA QUEST Integration, complete the QUEST Integration Additional Contracting Requirements Forms (pages Q-1 to Q-3)**
  - **Medicaid Provider Application/Change Request form (DHS 1139) Attestation**
    As of January 1, 2018, providers must complete and submit the Medicaid Provider Application/Change Request Form, also called the DHS 1139 form to the State Medicaid Agency, Department of Human Services (DHS) Med-QUEST Division (MQD). You can download the 1139 application and instructions from MQD's website at: **https://medquest.hawaii.gov/en/plans-providers/become-a-medicaid-provider.html**. Please attest if this requirement has been completed.
  - **Cultural Competency Plan**
    For QUEST Integration, providers need to attest that they're aware of and will follow and incorporate into their practice the HMSA QUEST Integration Cultural Competency Plan. The link to the Cultural Competency Plan: **hmsa.com/portal/provider/zav_qi.02.cul.50.htm**.
  - **Disclosure of Ownership Form**
    HMSA QUEST Integration will ensure that contracted providers submit full disclosures as specified in 42 CRF§ 455 Subpart B prior to execution of the provider agreement. The disclosure is to confirm that no excluded persons are working as managing employees or have an ownership or controlling interest in the provider business entity.

REQUIRED DOCUMENTS – Submit one copy of each document, if applicable

- ☐ **W-9 Form: Request for Taxpayer Identification Number and Certification or Copy of IRS Letter 147C**

An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA PROVIDER APPLICATION FORM FOR BUSINESS/FACILITY

PLEASE PRINT USING BALLPOINT PEN OR TYPE. (Write "N/A" in non-applicable sections.)

I. BUSINESS/FACILITY INFORMATION:

Organization NPI:	Federal Tax ID #:	
Business/Facility Legal Name:	Business/Facility Business Name (Trade Name):	
Facility Accredited: ☐ Yes ☐ No	If facility accredited, by what organization:	Effective Date of Accreditation:
Interested in participation with HMSA? ☐ Yes ☐ No	Hawaii State License #:	Date Issued:

Languages Spoken by **Office Staff** at this location (please check appropriate boxes):

☐ Cantonese	☐ Japanese	☐ Tagalog	☐ Other languages (List):
☐ French	☐ Korean	☐ Thai	_____
☐ German	☐ Mandarin	☐ Tongan	_____
☐ Hawaiian	☐ Samoan	☐ Vietnamese	_____
☐ Ilocano	☐ Spanish	☐ American Sign Language	☐ Access to Interpreter Services

II. PROGRAMS AVAILABLE:

☐ **Preferred Provider Plan**

☐ **Medicare Plans**
CMS participating status:
☐ Participating
☐ Nonparticipating
☐ Opt Out (Please provide a copy of the affidavit)
Effective date of Opt Out: _____

☐ **HMO**

☐ **QUEST Integration***
*If participating in QUEST Integration complete pages (Q1-Q3)

☐ **Special Vision (Optical)**

☐ **Veterans Affairs**
Patient Centered Community Care

III. APPLICATION CONTACT:

Name:	Phone No.:	Email:

IV. BUSINESS/FACILITY LOCATION ADDRESS (Include suite/room no):

Primary Location (check appropriate box): ☐ Yes ☐ No	Effective Date of Practice:	☐ Do not publish this location		
Building Name (if applicable):				
Address:	City:	State:	ZIP Code:	
Email Address:	Practice Website URL (if applicable):			
Appointment Phone Number (will be published in the directories):	Contact Phone Number (will be published if no Appointment Phone Number provided):			
Fax Number:	Referral Fax Number:			
NCPDP No. (Pharmacies Only):	DEA No.:			
Would you like correspondence be sent to your Email address above? ☐ Yes ☐ No	Does your facility/office have Americans with Disabilities Act (ADA) Accommodations? ☐ Yes ☐ No			

NOTE: If you have additional locations, please submit multiple copies of this page

V. MAILING ADDRESS FOR CORRESPONDENCE (Include suite/room no. or P.O. Box):

Building Name (If applicable):			
Address:	City:	State:	ZIP Code:

VI. BILLING ADDRESS FOR PAYMENT (Include suite/room no. or P.O. Box):

Building Name (if applicable):			
Address:	City:	State:	ZIP Code:

VII. ATTESTATION

I hereby affirm that all of the information submitted in this application is complete, accurate, and true to the best of my information, knowledge and belief. If I have signed this form electronically, it means that I acknowledge and agree to the terms of this form and so indicate by typing my name below as my electronic signature, executed and adopted by me with the intent to sign this document. In other words, typing my name as an electronic signature indicates that I acknowledge and agree to the terms of this form just as a handwritten signature would on a traditional paper form.

Signature	Date:
Printed Name:	Position (e.g. Owner, Administrator, Manager):

Please return application and attachments to:
Hawai'i Medical Service Association
Attn: Provider Operations, KLCR-PDA
P.O. Box 860
Honolulu, HI 96808-0860

Phone 952-7847 (Oahu) or
1 (800) 603-4672 ext. 7847 toll-free (Neighbor Islands)
Fax: 948-8210 on Oahu
Email: Provider_data@hmsa.com

QUEST INTEGRATION ADDITIONAL CONTRACTING REQUIREMENTS (PAGES Q-1 TO Q-3)

MEDICAID PROVIDER APPLICATION/CHANGE REQUEST FORM (DHS 1139) ATTESTATION

To improve Medicaid fraud prevention, the State Medicaid Agency, Department of Human Services (DHS) Med-QUEST Division (MQD) is required to perform more comprehensive screening, credentialing and enrollment for all providers. Starting January 1, 2018, providers must complete and submit the Medicaid Application/Change Request Form, also called the DHS 1139 Form. You can download the DHS 1139 Form and instructions from the MQD's website at: https://medquest.hawaii.gov/en/plans-providers/become-a-medicaid-provider.html. If you have any questions, contact the Department of Human Services, Med-QUEST Division via email at hcsbinquiries@dhs.hawaii.gov or telephone at 808-692-8099.

☐ **Yes**: I completed and submitted the Medicaid Provider Application/Change Request Form (DHS 1139 form).

Note: *You are required to renew and resubmit with the State every 5 years.*

☐ **No**: I have not completed and submitted the Medicaid Application/Change Request Form (DHS 1139 form).

Note: *Your HMSA participation is contingent upon completing and submitting the completed DHS form to the State of Hawaii Med QUEST Division.*

CULTURAL COMPETENCY PLAN

Providers: Acknowledge that you're aware of, will follow, and will incorporate into your practice HMSA's QUEST Integration Cultural Competency Plan. The QUEST Integration Cultural Competency Plan can be found here: hmsa.com/portal/provider/zav_qi.02.cul.50.htm.	☐ Yes	☐ No

ATTESTATION

I hereby affirm that the above information is complete, accurate, and true to the best of my information, knowledge, and belief. If I have signed this form electronically, it means that I acknowledge and agree to the terms of this form and so indicate by typing my name below as my electronic signature, executed and adopted by me with the intent to sign this document. In other words, typing my name as an electronic signature indicates that I acknowledge and agree to the terms of this form just as a handwritten signature would on a traditional paper form.

Signature:	Date:
Printed Name:	Position (e.g. Owner, Administrator, Manager):

DISCLOSURE OF OWNERSHIP (REQUIRED TO PARTICIPATE IN THE HMSA QUEST INTEGRATION PROGRAM)

Med-QUEST Hawaii requires disclosure information (as identified in 42 CFR § 455 Subpart B) before a provider agreement can be made. List each individual or corporation with a 5 percent or more ownership or controlling interest in the provider business entity. Also, provide the requested information for all of the applicant's managing employees. Attach additional pages as needed.

SECTION I: OWNER (INDIVIDUAL)

Name (Individual):	Start Date of Ownership:	End Date:
Title (Choose one): ☐ Owner/Company ☐ Owner/Individual ☐ Chief Executive Officer ☐ Chief Financial Officer ☐ Chief Information Officer ☐ Chief Operating Officer ☐ Board of Directors ☐ Managing Employee ☐ Employee ☐ Contractor	Has this individual been: ☐ convicted, ☐ debarred, ☐ suspended, or ☐ none of the above?	
Date of Birth:	Social Security Number:	
Address:		

Are you the spouse, parent, child or sibling of another person with an ownership or controlling interest in the provider?	☐ Yes	☐ No
Do you have an ownership or controlling interest in a subcontractor of the provider?	☐ Yes	☐ No
If yes, does the provider have a 5 percent or more interest in that subcontractor?	☐ Yes	☐ No
Name any other providers (individual or group practices) in which you have an ownership or controlling interest:		

SECTION II: OWNER (CORPORATE)

Name (corporation):	Start Date:	End Date:
Primary Business Address:		
Mailing Address (P.O. Box):		
Other Business Address(es):		
Tax Identification Number:		

a. Please provide the tax identification number of any entity with an ownership or controlling interest in any subcontractor of the provider if the provider has 5 percent of more interest in that subcontractor:	Tax ID number:	
b. Is the corporation the spouse, parent, child or sibling of another person with ownership or controlling interest?	☐ Yes	☐ No
c. Does the corporation have an ownership or controlling interest in a subcontractor to the provider?	☐ Yes	☐ No
If yes, does the provider have a 5 percent or more interest in that subcontractor?	☐ Yes	☐ No
d. Other providers (individual or group practices) over which the corporation has an ownership or controlling interest:		
e. Has this corporation been: ☐ convicted, ☐ debarred, ☐ suspended, or ☐ none of the above?		

SECTION III: MANAGING EMPLOYEE INFORMATION

A managing employee is a "general manager", business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly indirectly conducts the day-to-day operations of an institution, organization, or agency." (42 CFR section 455.101). Managing employees are in a position to exert influence over the conduct of the provider's operations.

Name:	Start Date:	End Date:

Title (Choose one):	Has this individual been:
☐ Owner/Company ☐ Owner/Individual ☐ Chief Executive Officer ☐ Chief Financial Officer ☐ Chief Information Officer ☐ Chief Operating Officer ☐ Board of Directors ☐ Managing Employee ☐ Employee ☐ Contractor	☐convicted, ☐ debarred, ☐ suspended, or ☐ none of the above?

Date of Birth:	Social Security Number:

Address:

SECTION IV: ADDITIONAL INFORMATION

a. 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 of fiscal year exceed the less of $25,000 or 5 percent of your total operating expense. (Attach extra page if necessary.) ☐ *Check here for N/A*

Name:

Address:

City:	State:	ZIP:

b. List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5 percent 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 of 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:

☐ **I don't have any managing employees, owners, or other Medicaid providers to report in Sections I, II, III or IV.**

ATTESTATION

I hereby affirm that the above information is complete, accurate, and true to the best of my information, knowledge, and belief. If I have signed this form electronically, it means that I acknowledge and agree to the terms of this form and so indicate by typing my name below as my electronic signature, executed and adopted by me with the intent to sign this document. In other words, typing my name as an electronic signature indicates that I acknowledge and agree to the terms of this form just as a handwritten signature would on a traditional paper form.

_____ _____
Signature Date

_____ _____
Printed or Stamped Name Social Security Number (last four digits only)

If the provider, any owner or managing employee is found to be on the List of Excluded Individuals and Entities (LEIE) maintained by the Office of Inspector General (OIG), HMSA will deny the application for participation in the HMSA QUEST Integration Program and Medicare programs. To see the list, go to the Department of Health and Human Services Office of Inspector General (HHS-OIG) online exclusion database at https://exclusions.oig.hhs.gov/.

QUEST Integration Disclosure of Information

To comply with Federal Regulations (42 CFR §455 Subpart B) and Med-QUEST Hawaii requirements providers who'd like to participate in QUEST Integration must complete this form for **each** managing employee, individual, or corporation with a 5 percent or more ownership or controlling interest in your business.

Definitions

Managing employee is a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution or agency.

Ownership interest is an ownership interest in a business entity that has a direct or indirect ownership interest in the disclosing entity.

Person with an ownership or controlling interest is a person or corporation that (a) has a direct or indirect ownership interest totaling 5 percent or more in a disclosing entity; (b) has a combination of direct or indirect ownership interests equal to 5 percent or more in a disclosing entity; (c) owns an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity if that interest equals 5 percent of the value of the property or assets of the disclosing entity; (d) is an officer or director of a disclosing entity that's organized as a corporation; (e) is a partner in a disclosing entity that's organized as a partnership.

If you don't have any managing employees or owners to report, check the box next to "I do not have any managing employees, owners, or other Medicaid providers to report in Sections I, II, III or IV."

If you, a managing employee, or an owner is on the list of excluded individuals maintained by the Department of Health and Human Services Office of Inspector General (HHS-OIG), the System for Award Management (SAM), or Med-QUEST Hawaii's excluded parties list, we must terminate your participation with HMSA QUEST Integration, Medicare and Veterans Administration (VA) programs. To verify, see the HHS-OIG online exclusion database at https://exclusions.oig.hhs.gov/