CNSI innovation@work

Individual Enrollment

HOKU New Application Path

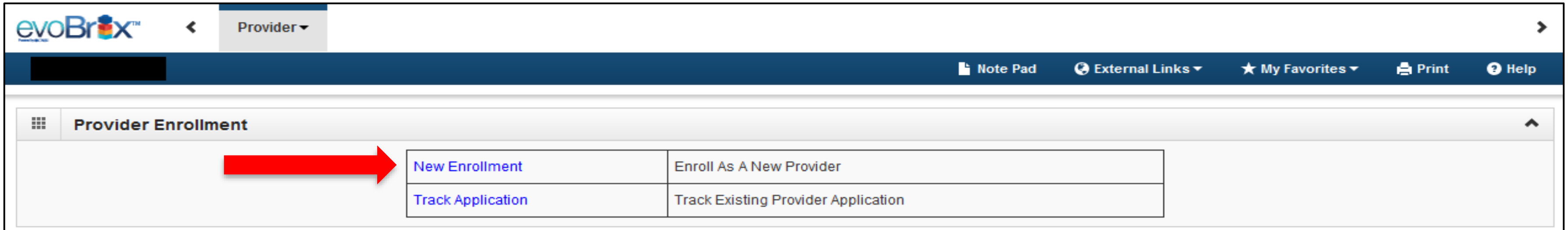
October 21, 2020

Selecting Individual Enrollment Type

- Select the Individual Enrollment Type if the provider being enrolled is an individual or sole proprietor operating his/her own medical/health care practice and has an NPI.
- These providers include:
  - Individual Doctors and Physicians in Private Practice
  - Nurse-Practitioners and Physician’s Assistants in Private Practice
  - Rendering/Servicing Only providers - Individuals with an NPI, but rendering/servicing only, another provider(s) (Individual or Organization) such as a parent physician or medical group conducting all billing for you
  - Psychologists
  - Audiologists
  - Dentists
  - Chiropractors
  - Occupational or Physical Therapists that have an NPI operating independently

©2019 CNSI

Provider Enrollment Application Selection


evoBrix
Provider
Note Pad
External Links
My Favorites
Print
Help
Provider Enrollment

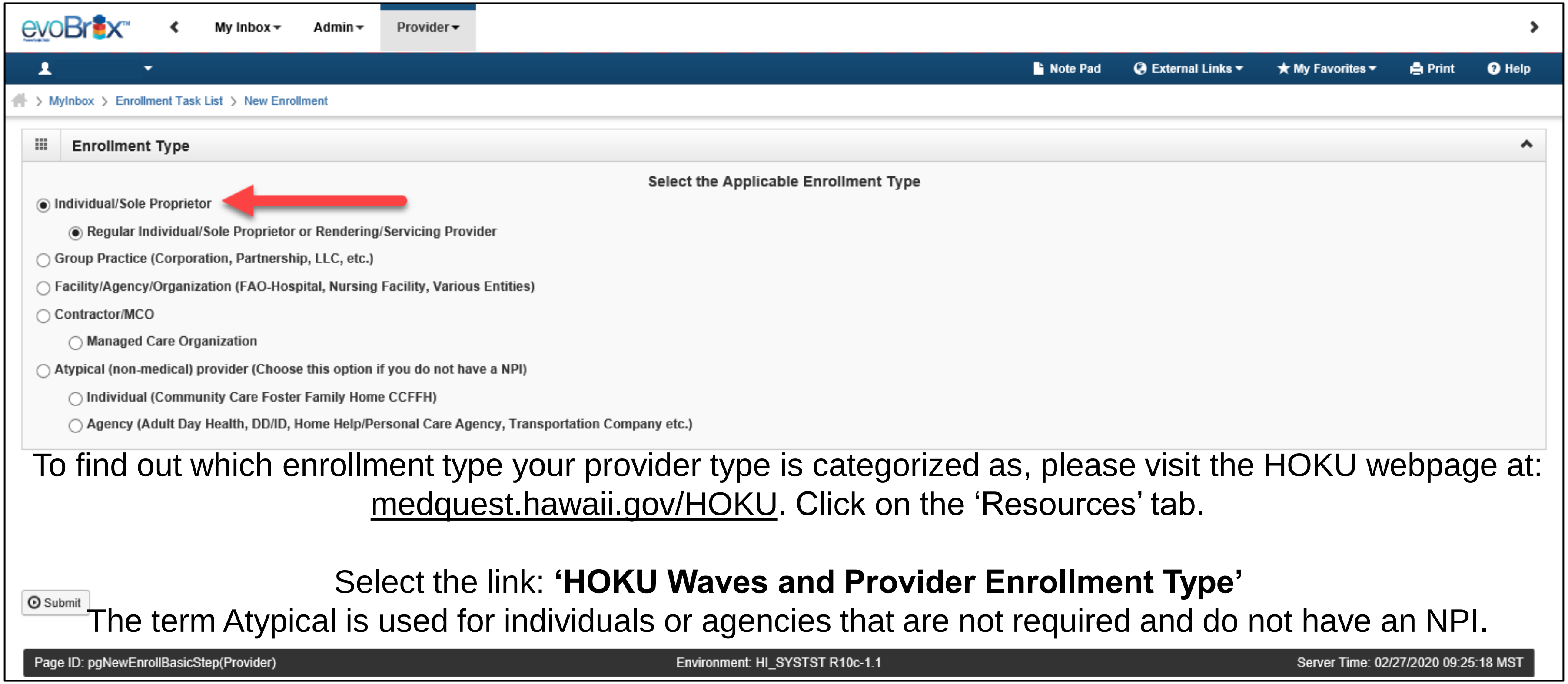
[redacted]

New Enrollment	Enroll As A New Provider
Track Application	Track Existing Provider Application

- If you are a **new** Hawaii Medicaid provider, you will select ‘**New Enrollment**.’
- If you are an **existing** Hawaii Medicaid provider and have a Med-QUEST Provider ID number, you should have received a letter with your application ID number, you will select ‘**Track Application**’ and input your application ID number on the next page and proceed to Slide 5 of this instructional slide deck.

©2019 CNSI

Select the Individual Enrollment Button


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment
Submit
Page ID: pgNewEnrollBasicStep(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/27/2020 09:25:18 MST

Enrollment Type

Select the Applicable Enrollment Type

- ● Individual/Sole Proprietor
  - ● Regular Individual/Sole Proprietor or Rendering/Servicing Provider
- ○ Group Practice (Corporation, Partnership, LLC, etc.)
- ○ Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)
- ○ Contractor/MCO
  - ○ Managed Care Organization
- ○ Atypical (non-medical) provider (Choose this option if you do not have a NPI)
  - ○ Individual (Community Care Foster Family Home CCFFH)
  - ○ Agency (Adult Day Health, DD/ID, Home Help/Personal Care Agency, Transportation Company etc.)

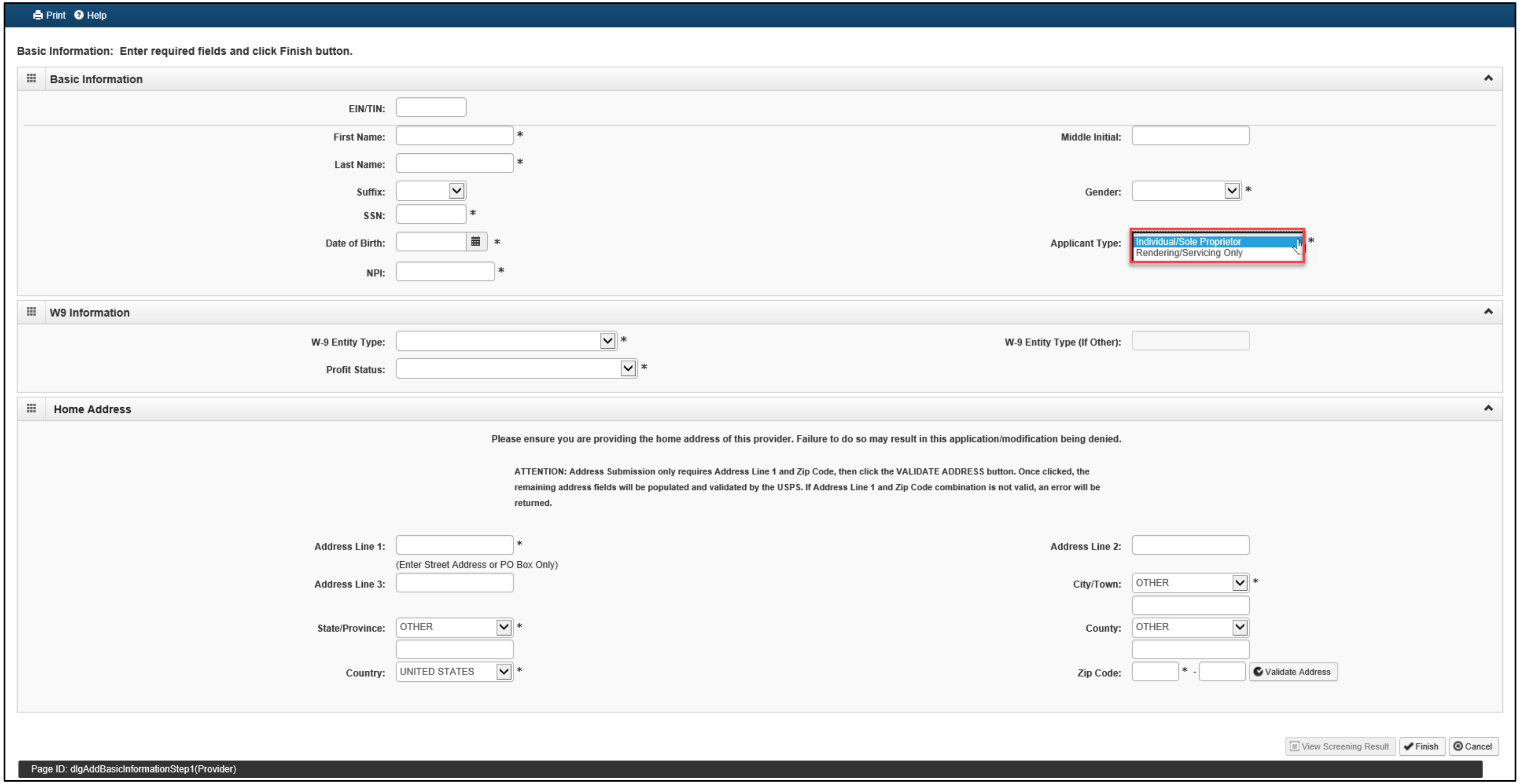
To find out which enrollment type your provider type is categorized as, please visit the HOKU webpage at: medquest.hawaii.gov/HOKU. Click on the ‘Resources’ tab.

Select the link: **‘HOKU Waves and Provider Enrollment Type’**

The term Atypical is used for individuals or agencies that are not required and do not have an NPI.

©2019 CNSI

Step 1: Provide Basic Information



Basic Information: Enter required fields and click Finish button.

Basic Information

EIN/TIN:
First Name: *
Middle Initial:
Last Name: *
Suffix:
Gender: *
SSN: *
Date of Birth: *
Applicant Type: Individual/Sole Proprietor
Rendering/Servicing Only *
NPI: *

W9 Information

W-9 Entity Type: *
W-9 Entity Type (If Other):
Profit Status: *

Home Address

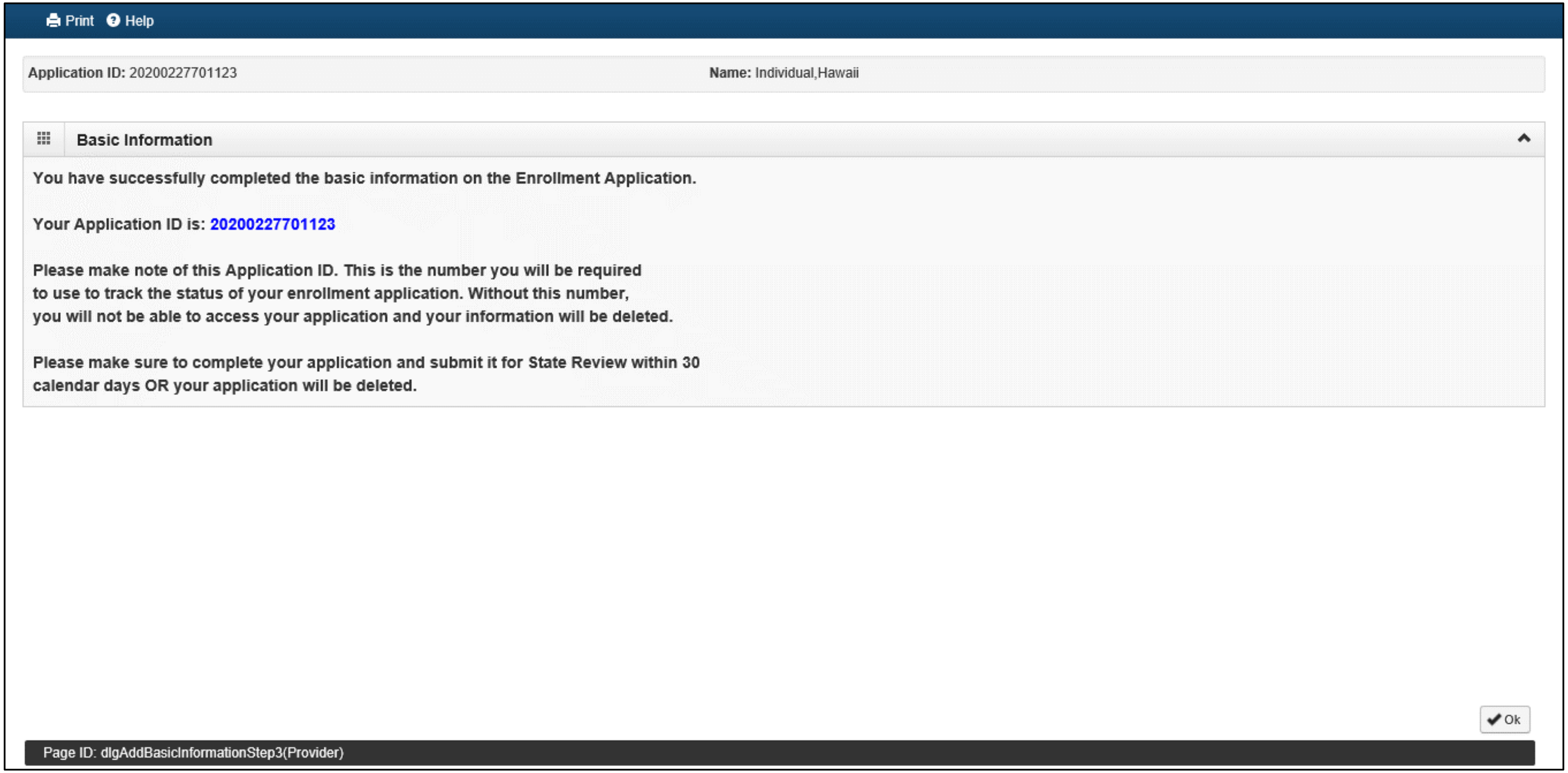
Please ensure you are providing the home address of this provider. Failure to do so may result in this application/modification being denied.

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address Line 1: * (Enter Street Address or PO Box Only)
Address Line 2:
Address Line 3:
City/Town: OTHER *
State/Province: OTHER *
County: OTHER
Country: UNITED STATES *
Zip Code: * -

Page ID: dlgAddBasicInformationStep1(Provider)

Application ID



Application ID: 20200227701123

Name: Individual,Hawaii

Basic Information

You have successfully completed the basic information on the Enrollment Application.

Your Application ID is: 20200227701123

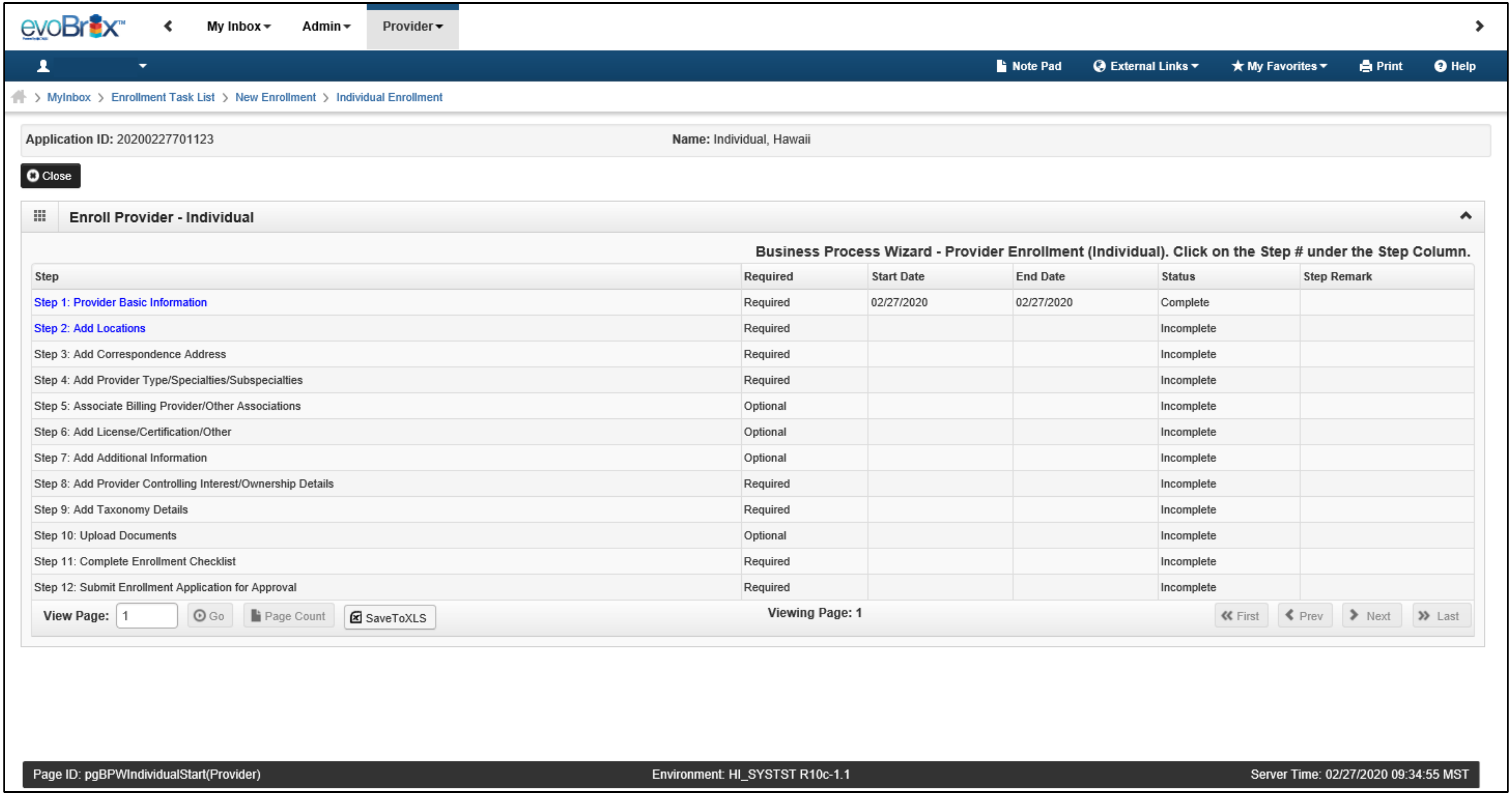
Please make note of this Application ID. This is the number you will be required to use to track the status of your enrollment application. Without this number, you will not be able to access your application and your information will be deleted.

Please make sure to complete your application and submit it for State Review within 30 calendar days OR your application will be deleted.

Page ID: dlgAddBasicInformationStep3(Provider)

©2019 CNSI

Enrollment Steps


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Go
Page Count
SaveToXLS
First
Prev
Next
Last

Application ID: 20200227701123 **Name:** Individual, Hawaii

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

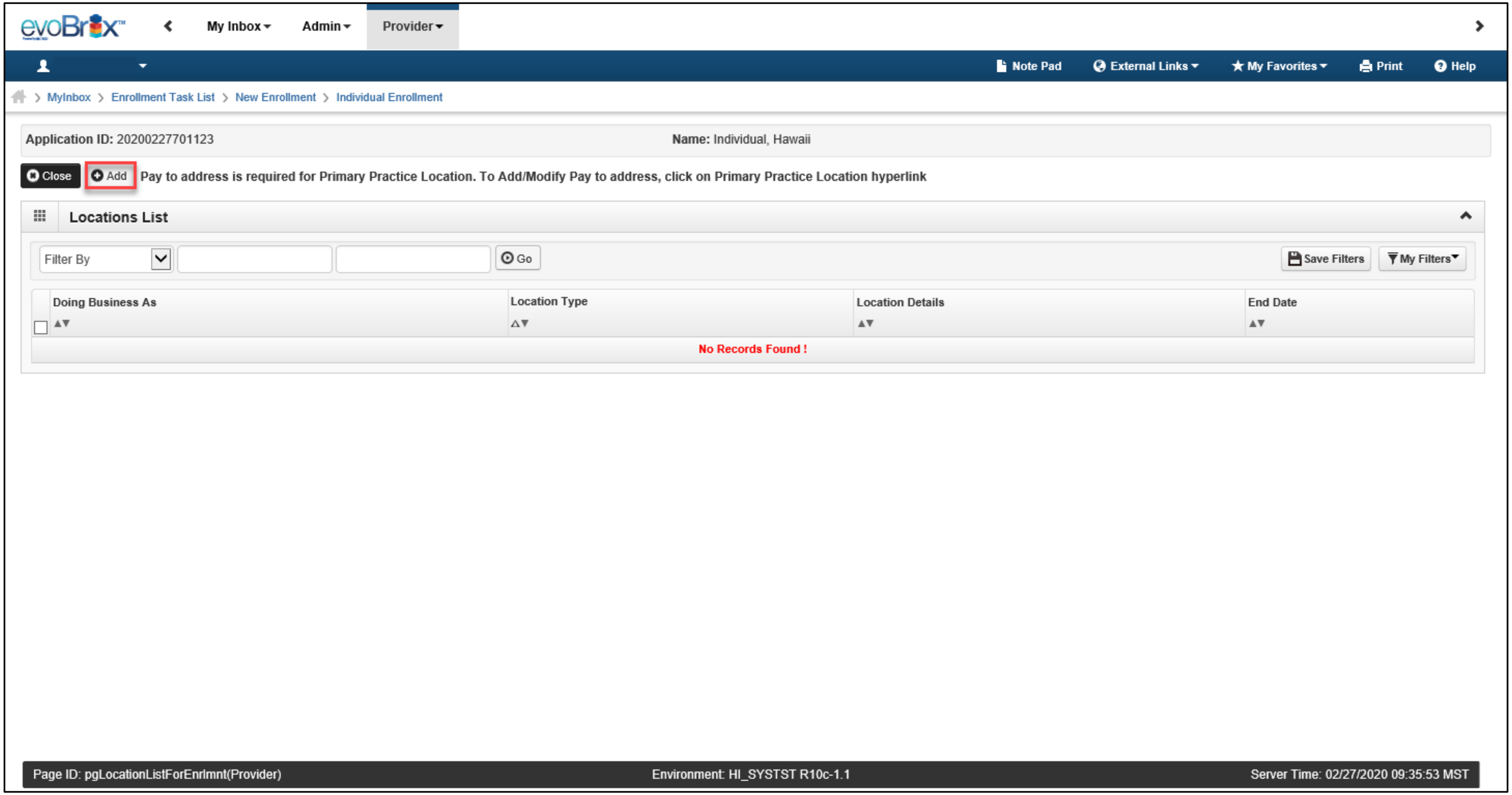
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/27/2020	02/27/2020	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Correspondence Address	Required			Incomplete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required			Incomplete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Additional Information	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Upload Documents	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 **Viewing Page: 1**

Page ID: pgBPWIndividualStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 09:34:55 MST

©2019 CNSI

Step 2: Add Locations


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Add
Filter By
Go
Save Filters
My Filters

Application ID: 20200227701123

Name: Individual, Hawaii

Pay to address is required for Primary Practice Location. To Add/Modify Pay to address, click on Primary Practice Location hyperlink

Locations List

☐	Doing Business As	Location Type	Location Details	End Date
	No Records Found !			

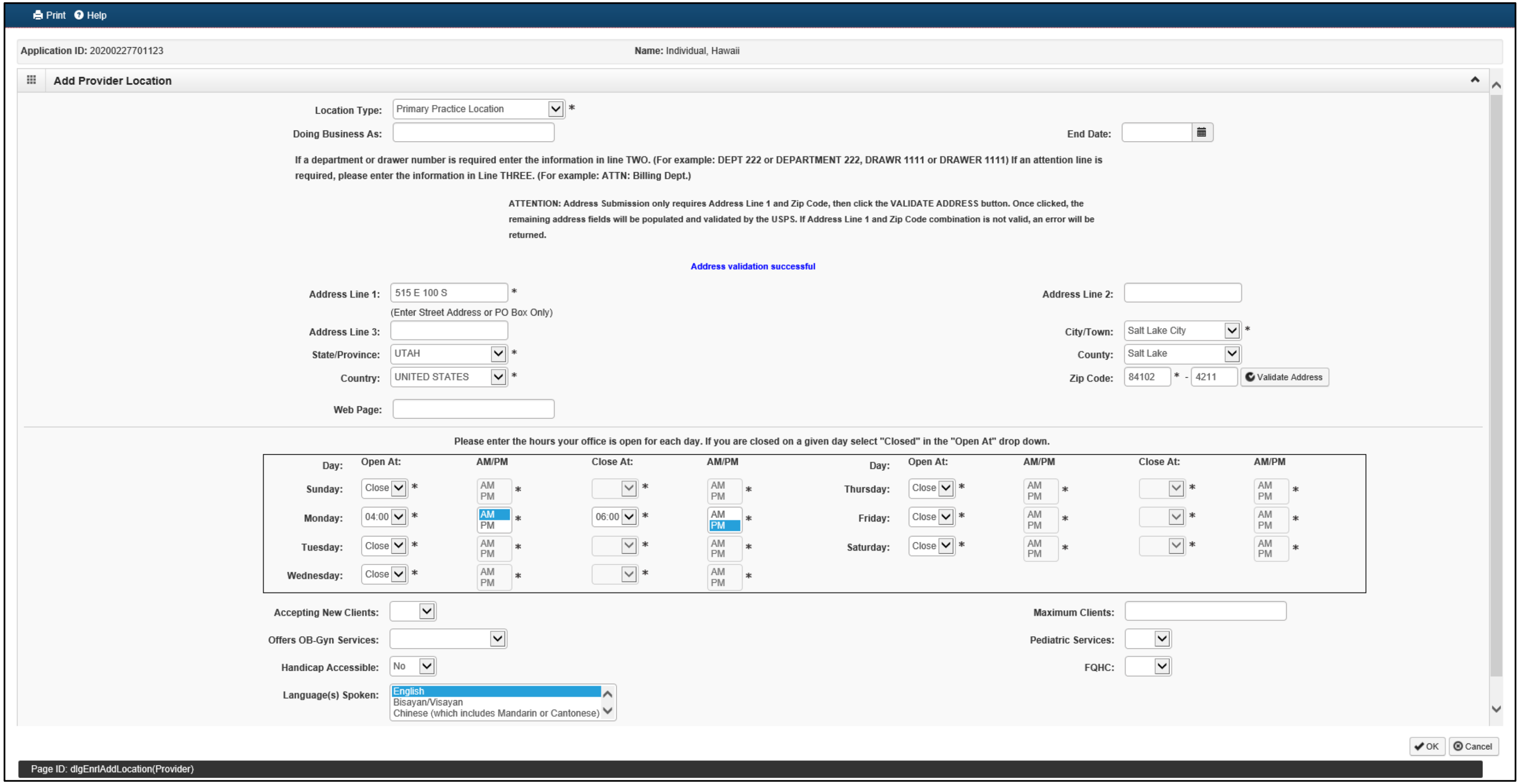
Page ID: pgLocationListForEnrlmnt(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/27/2020 09:35:53 MST

©2019 CNSI

Add Primary Practice Address



Application ID: 20200227701123 **Name:** Individual, Hawaii

Add Provider Location

Location Type: Primary Practice Location *
Doing Business As:
End Date:

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address validation successful

Address Line 1: 515 E 100 S *
(Enter Street Address or PO Box Only)
Address Line 2:
Address Line 3:
City/Town: Salt Lake City *
State/Province: UTAH *
County: Salt Lake
Country: UNITED STATES *
Zip Code: 84102 * - 4211
Web Page:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

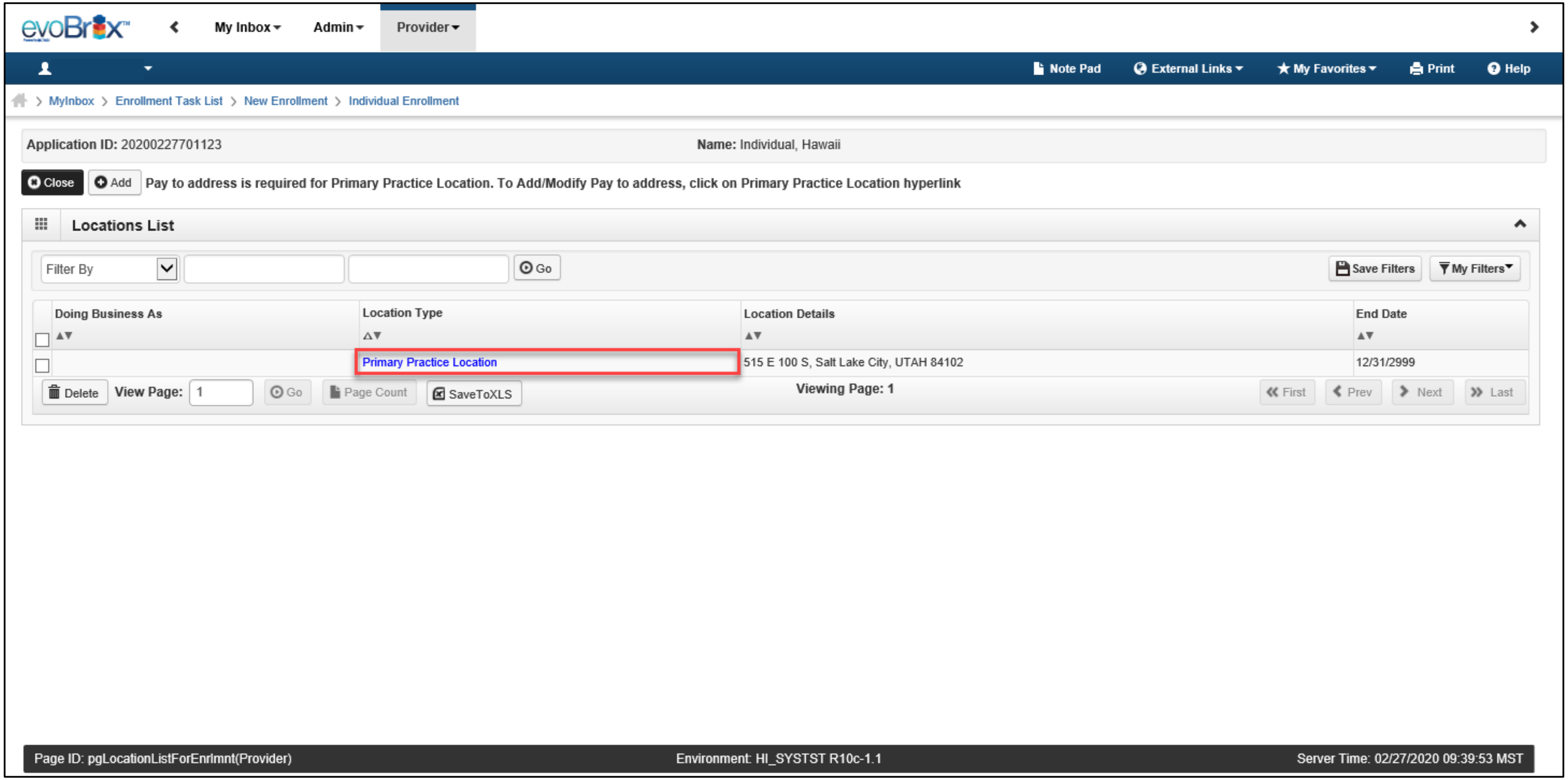
Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close *	AM PM *	*	AM PM *	Thursday:	Close *	AM PM *	*	AM PM *
Monday:	04:00 *	AM *	06:00 *	PM *	Friday:	Close *	AM PM *	*	AM PM *
Tuesday:	Close *	AM PM *	*	AM PM *	Saturday:	Close *	AM PM *	*	AM PM *
Wednesday:	Close *	AM PM *	*	AM PM *					

Accepting New Clients:
Maximum Clients:
Offers OB-Gyn Services:
Pediatric Services:
Handicap Accessible: No
FQHC:
Language(s) Spoken: English
Bisayan/Visayan
Chinese (which includes Mandarin or Cantonese)

Page ID: dlgEnrlAddLocation(Provider)

©2019 CNSI

Add Pay To Address


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Add
Locations List
Filter By
Go
Save Filters
My Filters
Delete
Go
Page Count
SaveToXLS
First
Prev
Next
Last

Application ID: 20200227701123

Name: Individual, Hawaii

Pay to address is required for Primary Practice Location. To Add/Modify Pay to address, click on Primary Practice Location hyperlink

☐	Doing Business As	Location Type	Location Details	End Date
☐		Primary Practice Location	515 E 100 S, Salt Lake City, UTAH 84102	12/31/2999

View Page: 1

Viewing Page: 1

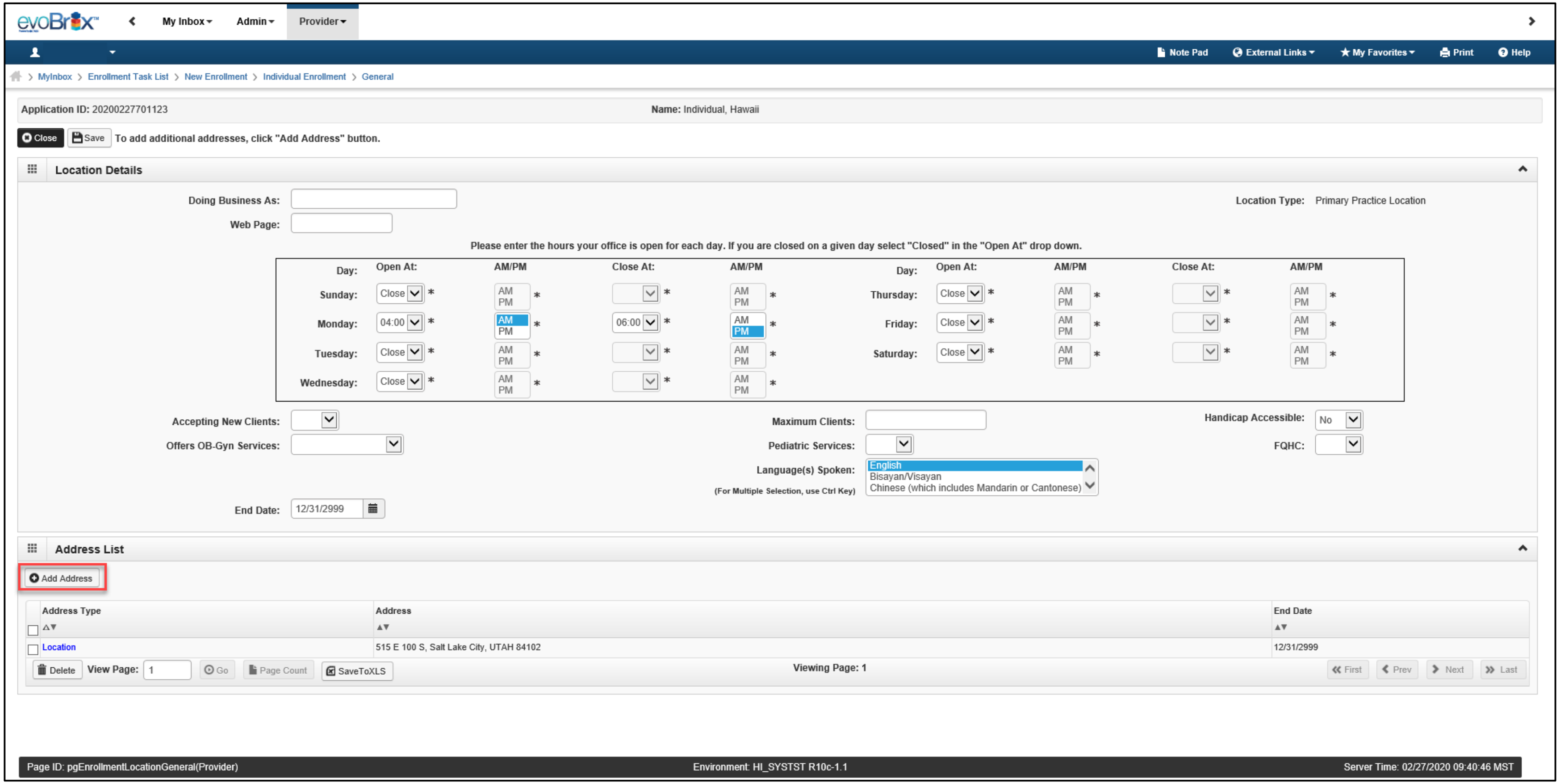
Page ID: pgLocationListForEnrlmnt(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/27/2020 09:39:53 MST

©2019 CNSI

Add Pay To Address


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment > General
Close
Save
Add Address

Application ID: 20200227701123

Name: Individual, Hawaii

To add additional addresses, click "Add Address" button.

Location Details

Doing Business As:

Web Page:

Location Type: Primary Practice Location

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close			
Monday:	04:00	AM	06:00	PM
Tuesday:	Close			
Wednesday:	Close			
Thursday:	Close			
Friday:	Close			
Saturday:	Close			

Accepting New Clients:

Offers OB-Gyn Services:

Maximum Clients:

Pediatric Services:

Language(s) Spoken: English
(For Multiple Selection, use Ctrl Key)
Options: English, Bisayan/Visayan, Chinese (which includes Mandarin or Cantonese)

Handicap Accessible: No

FQHC:

End Date: 12/31/2999

Address List

☐	Address Type	Address	End Date
☐	Location	515 E 100 S, Salt Lake City, UTAH 84102	12/31/2999

Delete View Page: 1 Go Page Count SaveToXLS

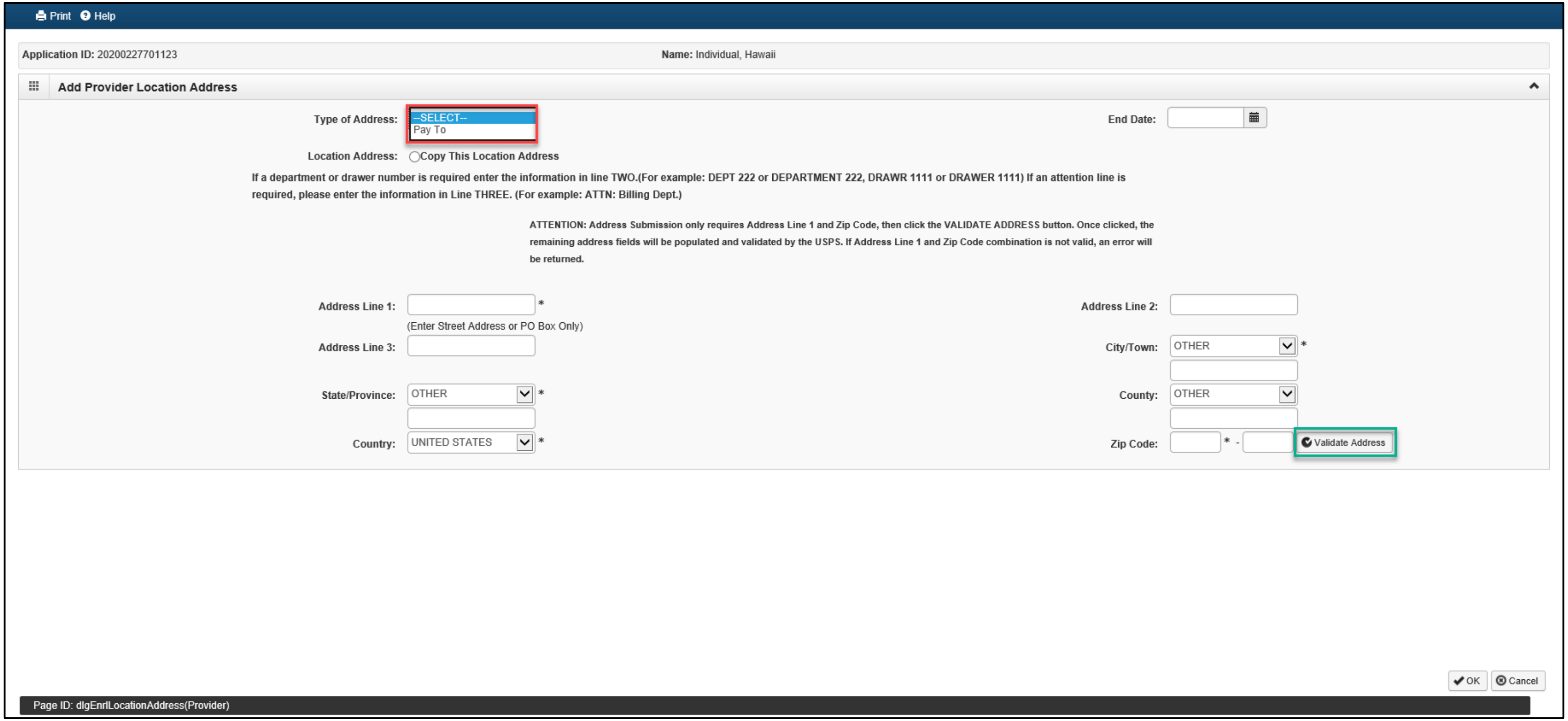
Viewing Page: 1

First Prev Next Last

Page ID: pgEnrollmentLocationGeneral(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/27/2020 09:40:46 MST

©2019 CNSI

Add Pay To Address



Application ID: 20200227701123

Name: Individual, Hawaii

Type of Address: --SELECT--
Pay To

End Date:

Location Address: ○ Copy This Location Address

If a department or drawer number is required enter the information in line TWO.(For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER *

State/Province: OTHER *

County: OTHER

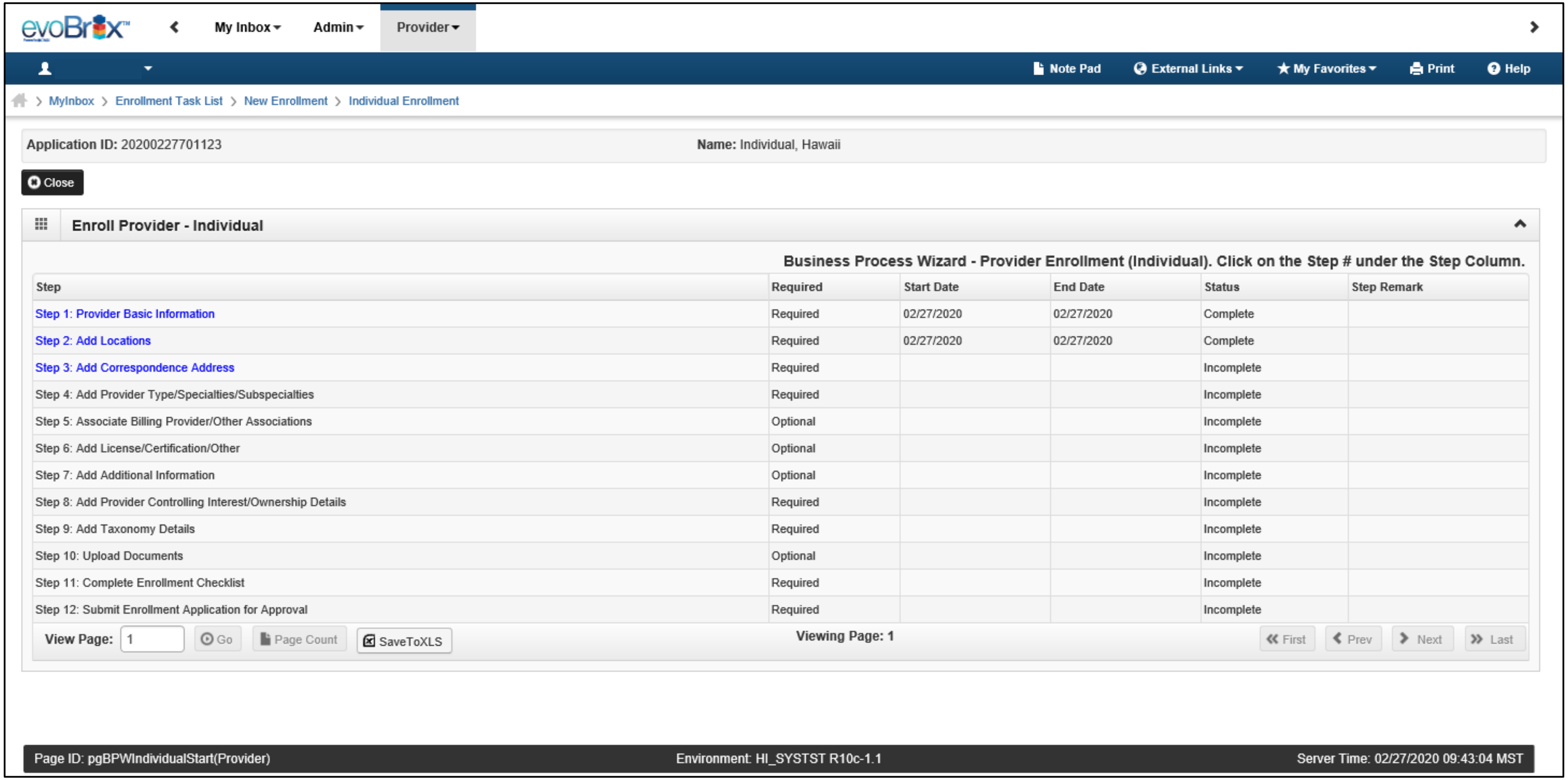
Country: UNITED STATES *

Zip Code: * -

Page ID: dlgEnrlLocationAddress(Provider)

©2019 CNSI

Step 3: Add Correspondence Address


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Go
Page Count
SaveToXLS
First
Prev
Next
Last

Application ID: 20200227701123 **Name:** Individual, Hawaii

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/27/2020	02/27/2020	Complete	
Step 2: Add Locations	Required	02/27/2020	02/27/2020	Complete	
Step 3: Add Correspondence Address	Required			Incomplete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required			Incomplete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Additional Information	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Upload Documents	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

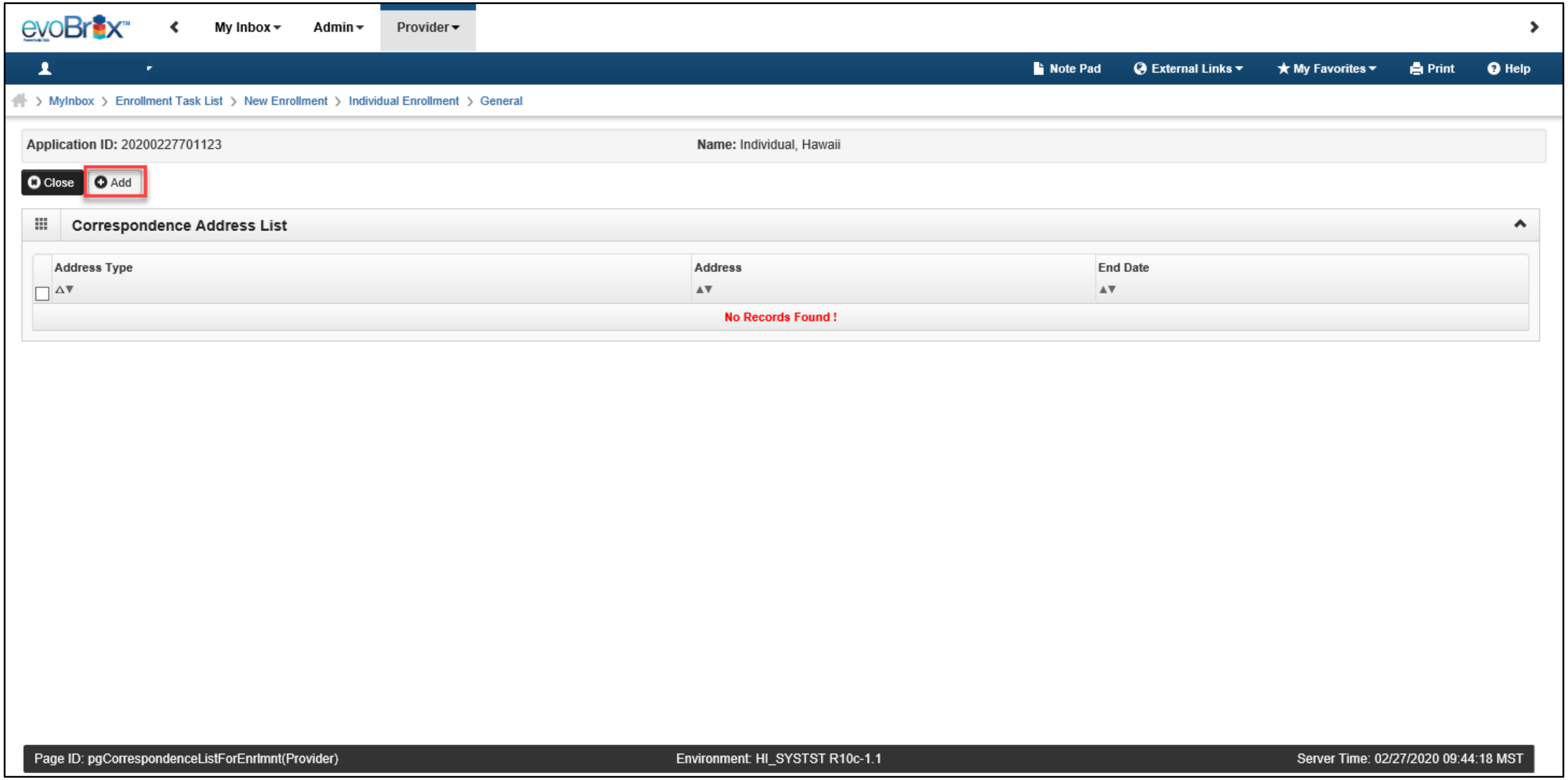
View Page: 1

Viewing Page: 1

Page ID: pgBPWIndividualStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 09:43:04 MST

©2019 CNSI

Add Correspondence Address


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment > General
Close
Add

Application ID: 20200227701123 **Name:** Individual, Hawaii

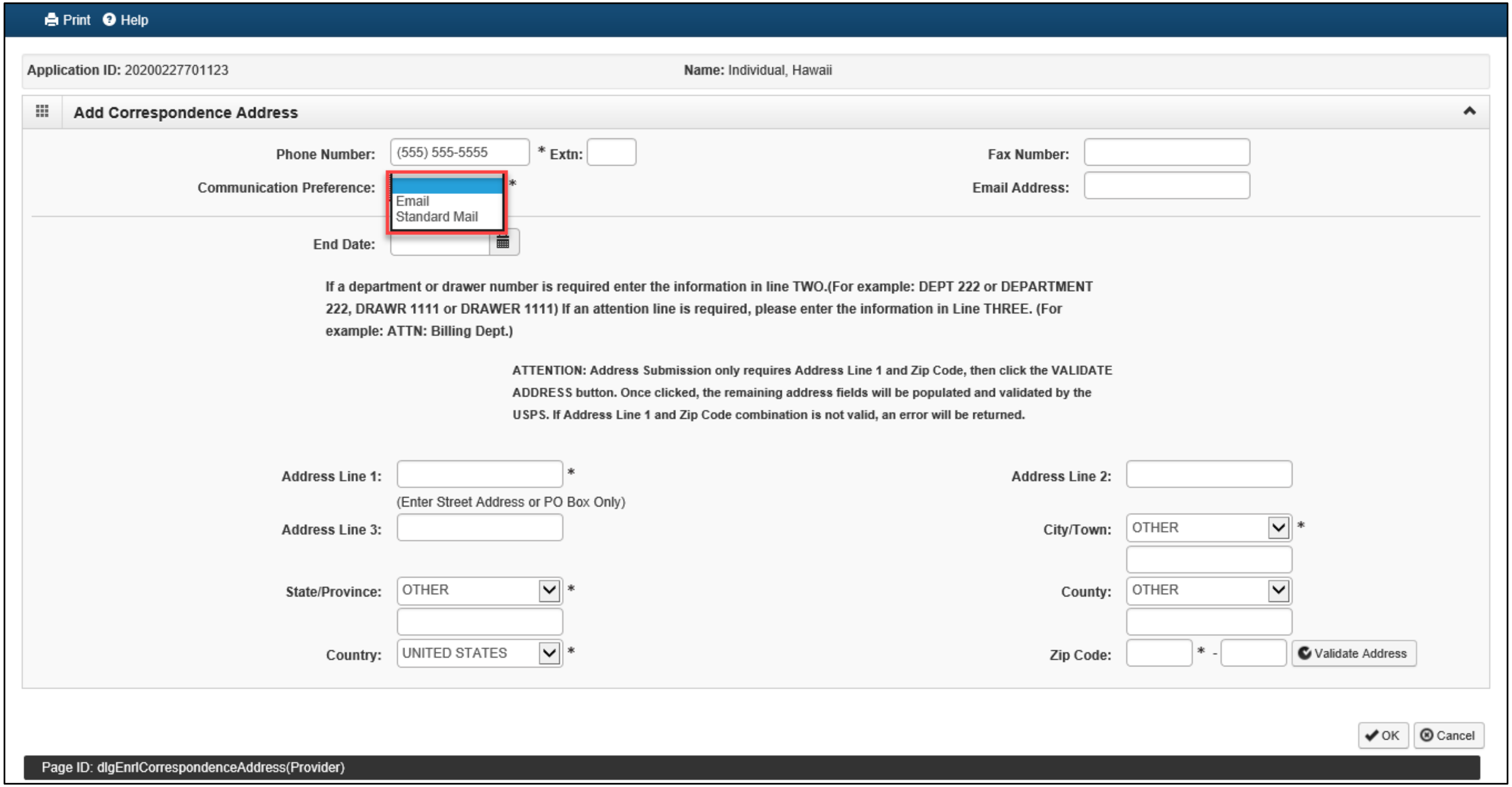
Correspondence Address List

☐	Address Type	Address	End Date
	No Records Found !		

Page ID: pgCorrespondenceListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 09:44:18 MST

©2019 CNSI

Add Correspondence Address



Application ID: 20200227701123

Name: Individual, Hawaii

Add Correspondence Address

Phone Number: (555) 555-5555 * **Extn:**

Fax Number:

Communication Preference: *
- Email
- Standard Mail

Email Address:

End Date:

If a department or drawer number is required enter the information in line TWO.(For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER *

State/Province: OTHER *

County: OTHER

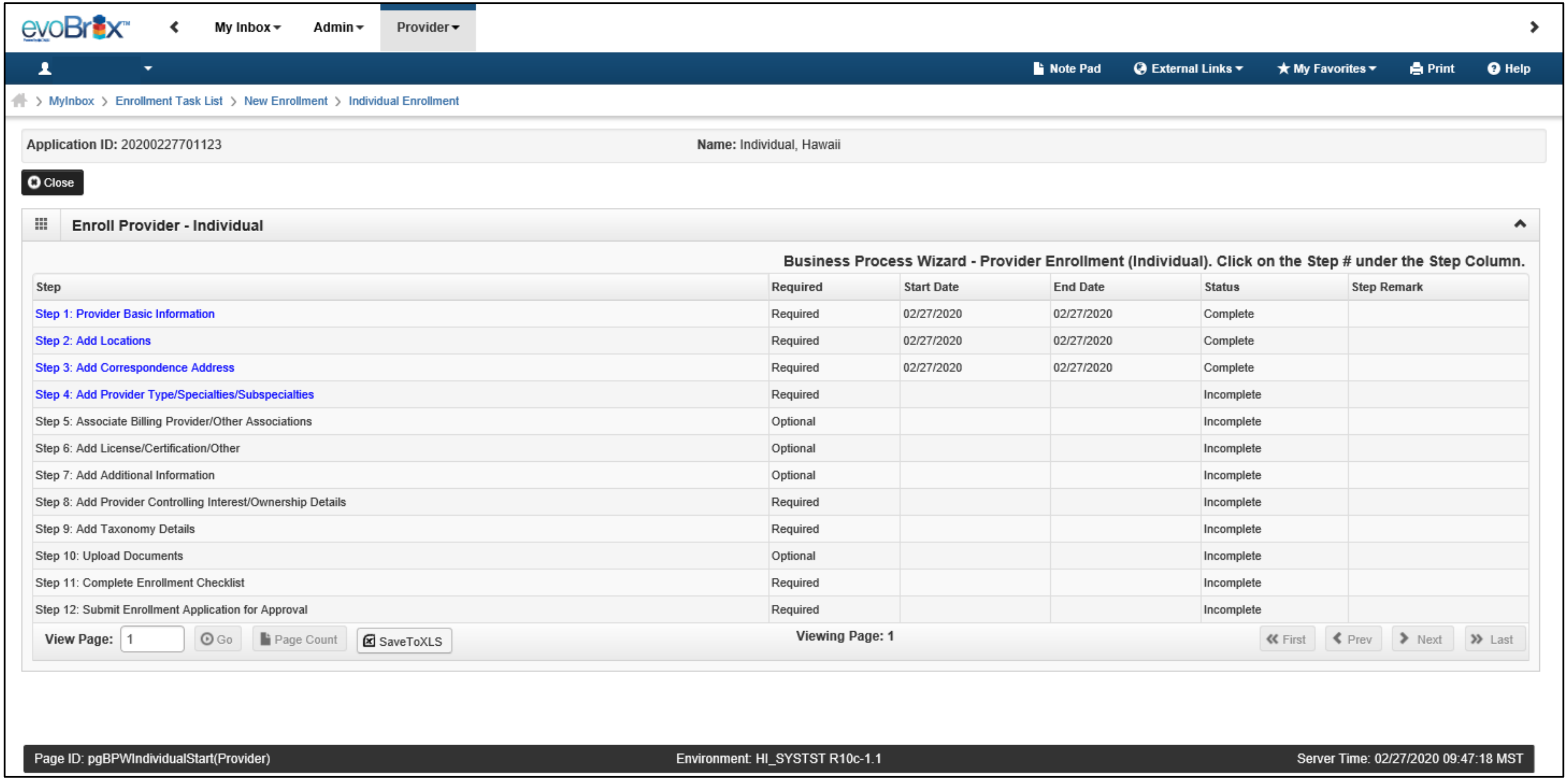
Country: UNITED STATES *

Zip Code: * -

Page ID: dlgEnrlCorrespondenceAddress(Provider)

©2019 CNSI

Step 4: Add Provider Type/Specialties/Subspecialties


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment

Application ID: 20200227701123 **Name:** Individual, Hawaii

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/27/2020	02/27/2020	Complete	
Step 2: Add Locations	Required	02/27/2020	02/27/2020	Complete	
Step 3: Add Correspondence Address	Required	02/27/2020	02/27/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required			Incomplete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Additional Information	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Upload Documents	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

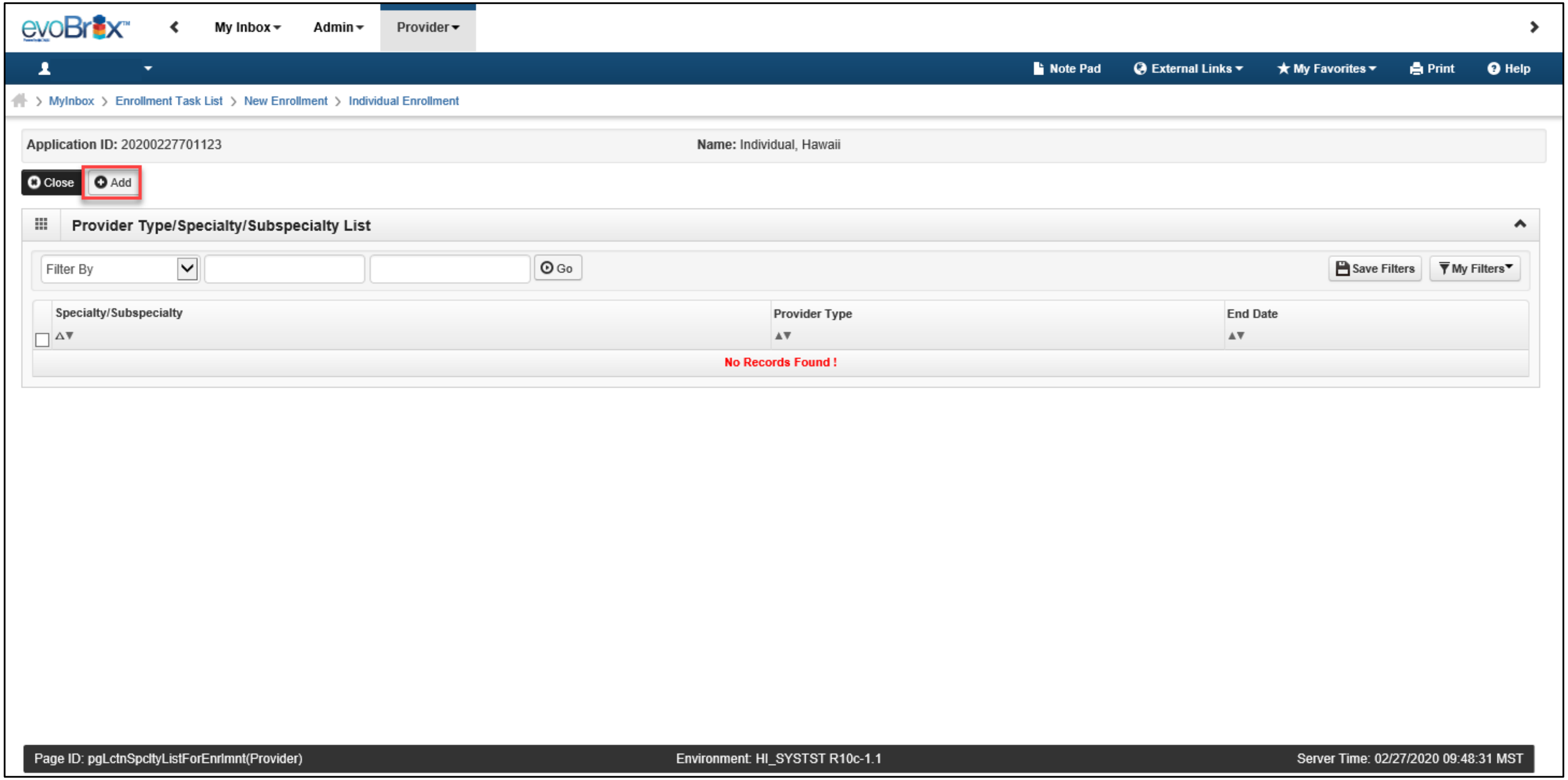
View Page: 1 Viewing Page: 1

Go
Page Count
SaveToXLS
First
Prev
Next
Last

Page ID: pgBPWIndividualStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 09:47:18 MST

©2019 CNSI

Add Provider Type/Specialties/Subspecialties


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Add
Filter By
Go
Save Filters
My Filters

Application ID: 20200227701123 **Name:** Individual, Hawaii

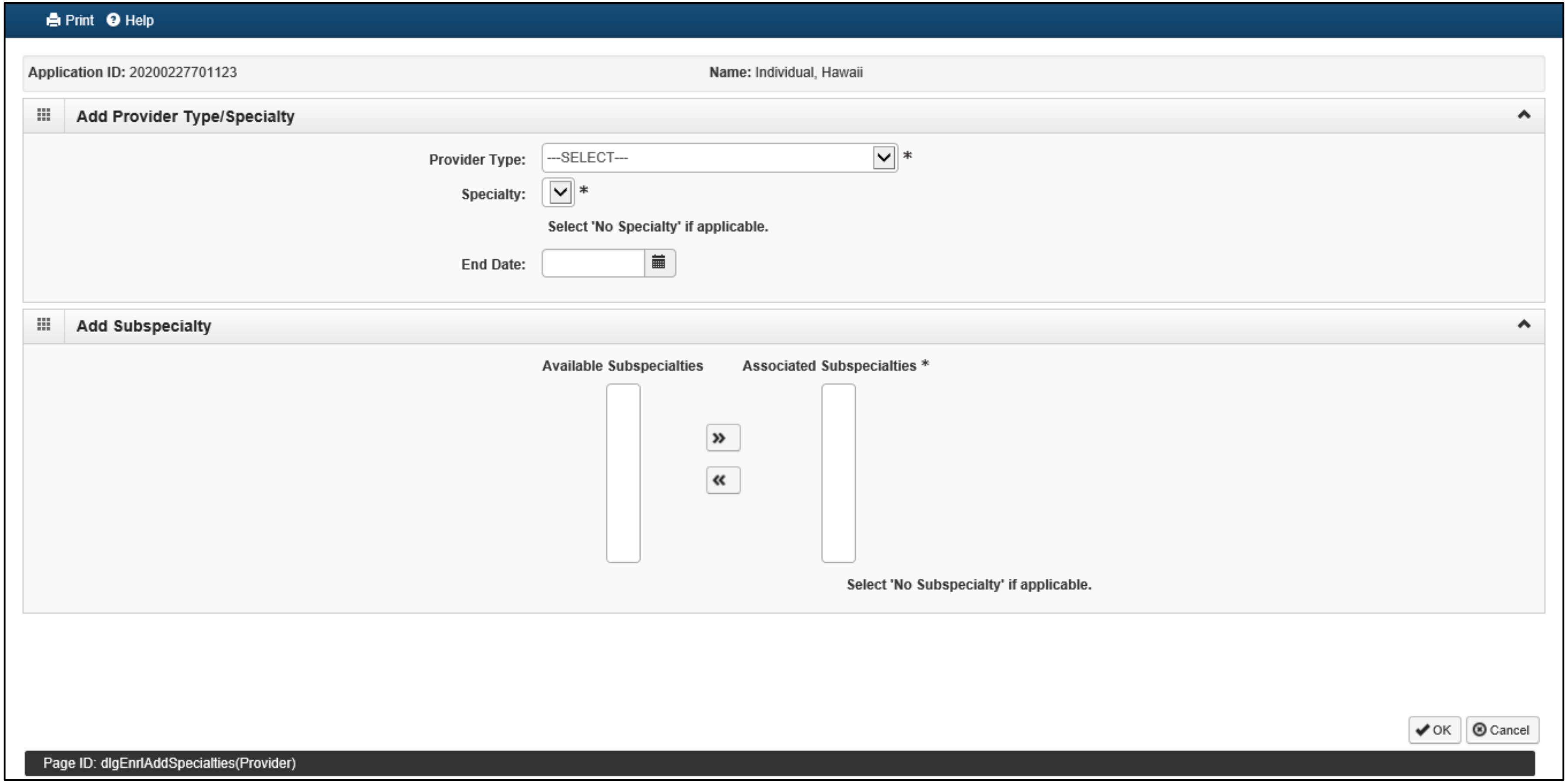
Provider Type/Specialty/Subspecialty List

☐	Specialty/Subspecialty	Provider Type	End Date
	No Records Found !		

Page ID: pgLctnSpcltyListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 09:48:31 MST

©2019 CNSI

Provider Type/Specialties/Subspecialties



Application ID: 20200227701123

Name: Individual, Hawaii

Add Provider Type/Specialty

Provider Type: ---SELECT--- *

Specialty: *

Select 'No Specialty' if applicable.

End Date:

Add Subspecialty

Available Subspecialties

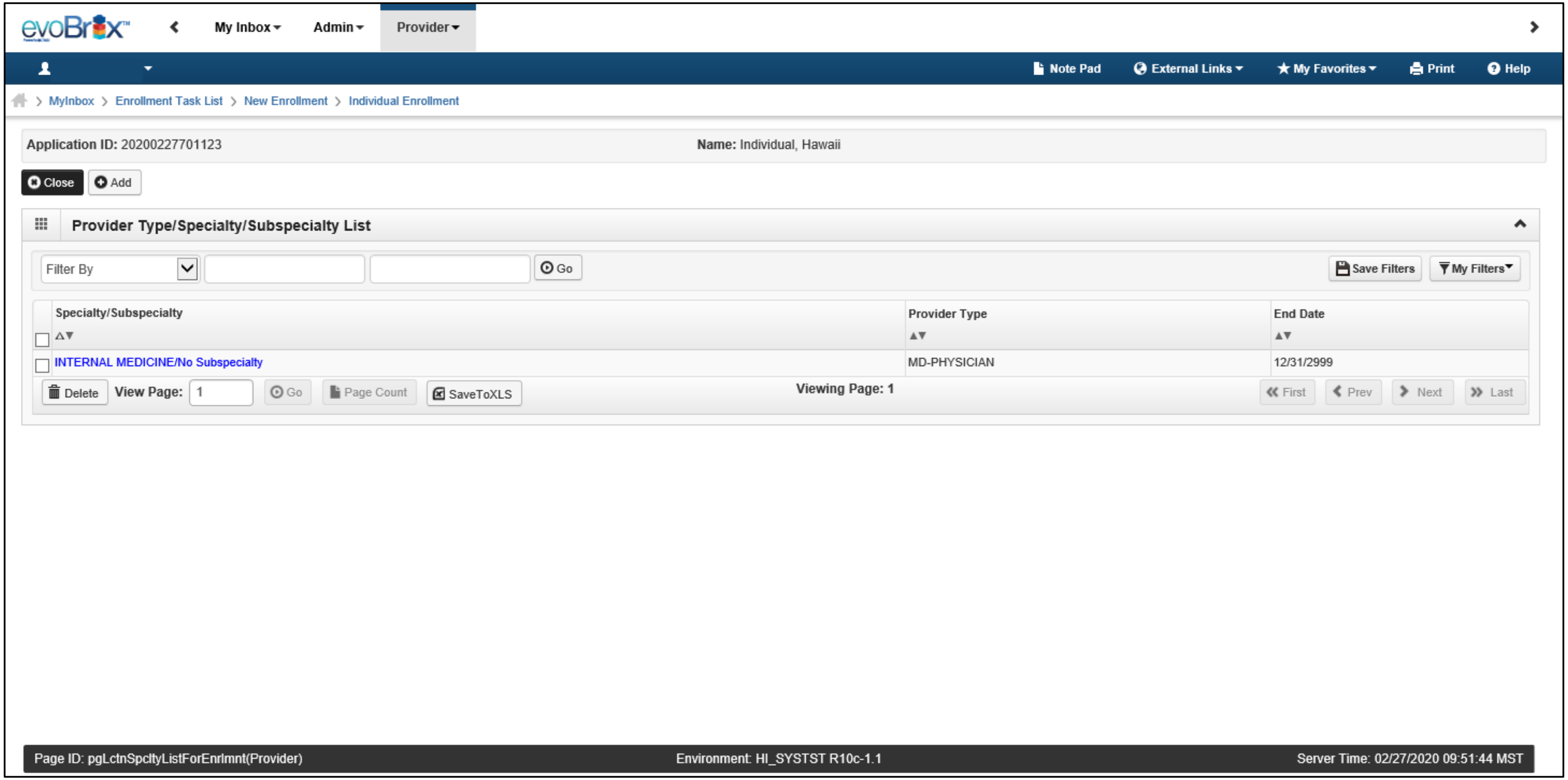
Associated Subspecialties *

Select 'No Subspecialty' if applicable.

Page ID: dlgEnrlAddSpecialties(Provider)

©2019 CNSI

Add Provider Type/Specialties/Subspecialties


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Add
Filter By
Go
Save Filters
My Filters
Delete
Go
Page Count
SaveToXLS
First
Prev
Next
Last

Application ID: 20200227701123 **Name:** Individual, Hawaii

Provider Type/Specialty/Subspecialty List

	Specialty/Subspecialty	Provider Type	End Date
☐	INTERNAL MEDICINE/No Subspecialty	MD-PHYSICIAN	12/31/2999

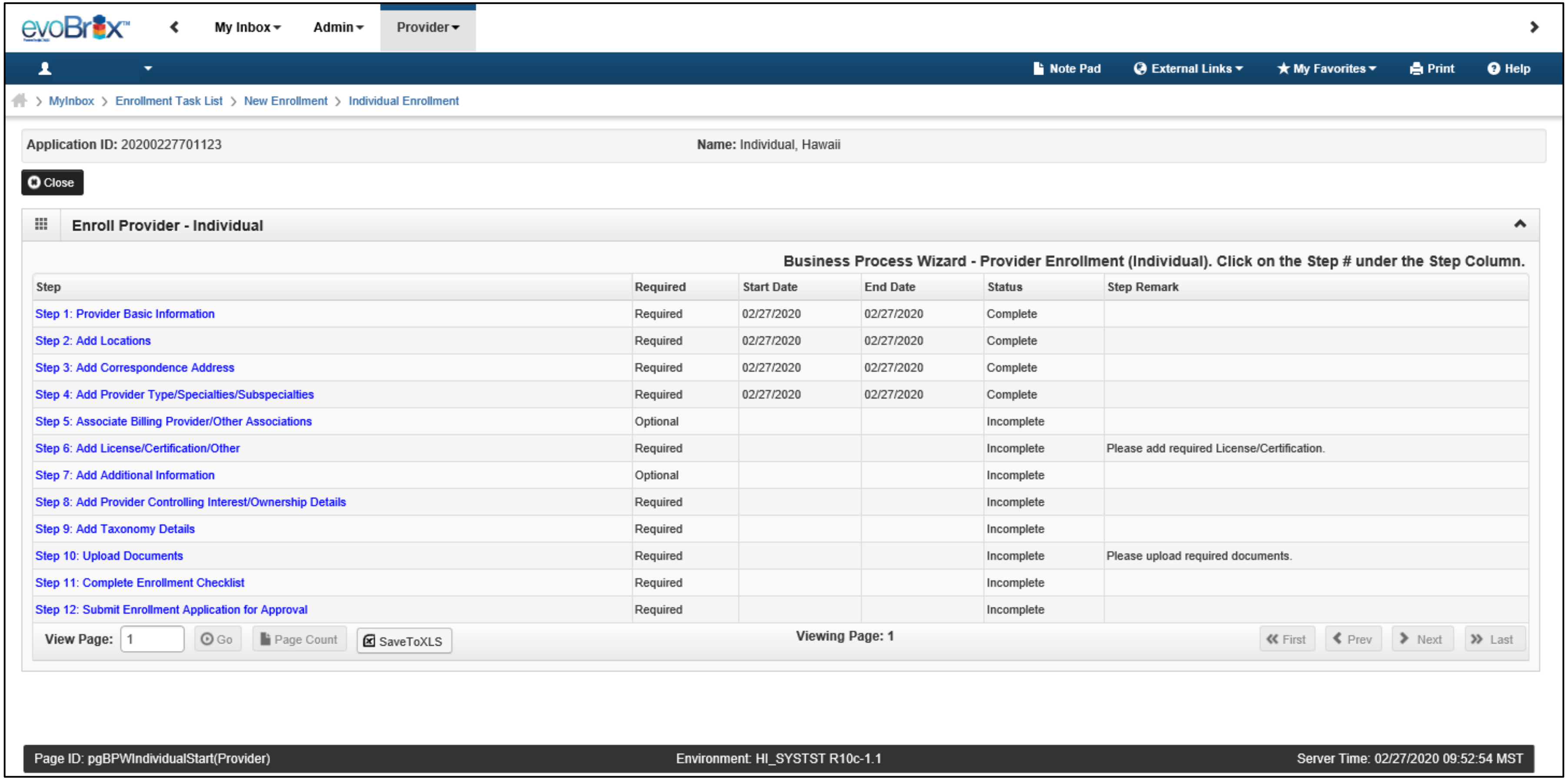
View Page: 1

Viewing Page: 1

Page ID: pgLctnSpcltyListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 09:51:44 MST

©2019 CNSI

Step 5: Associate Billing Provider


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Enroll Provider - Individual
Go
Page Count
SaveToXLS
First
Prev
Next
Last

Application ID: 20200227701123 **Name:** Individual, Hawaii

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/27/2020	02/27/2020	Complete	
Step 2: Add Locations	Required	02/27/2020	02/27/2020	Complete	
Step 3: Add Correspondence Address	Required	02/27/2020	02/27/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/27/2020	02/27/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add License/Certification/Other	Required			Incomplete	Please add required License/Certification.
Step 7: Add Additional Information	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Upload Documents	Required			Incomplete	Please upload required documents.
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

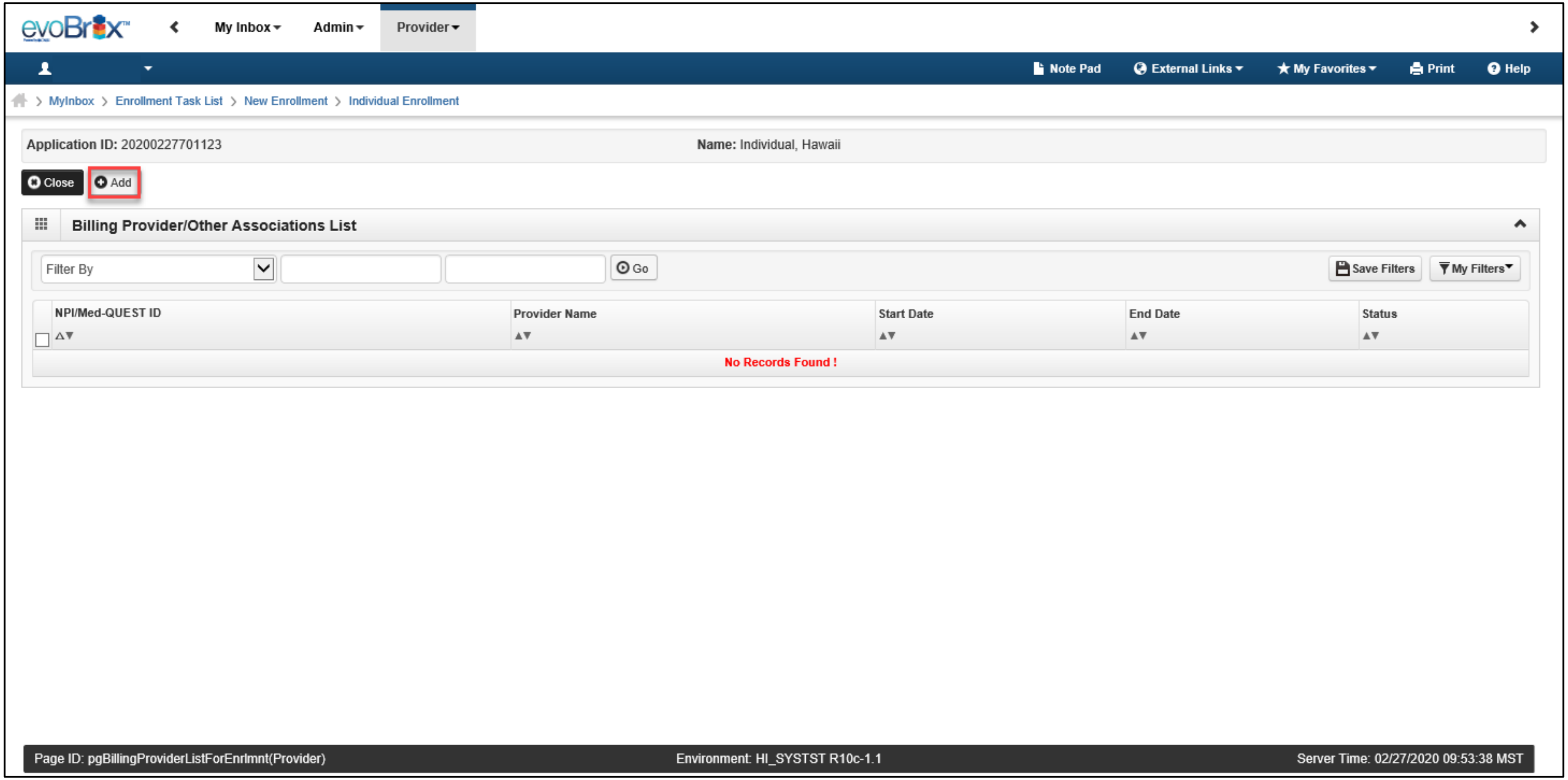
View Page: 1

Viewing Page: 1

Page ID: pgBPWIndividualStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 09:52:54 MST

©2019 CNSI

Associate Billing Provider


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Add
Billing Provider/Other Associations List
Filter By
Go
Save Filters
My Filters

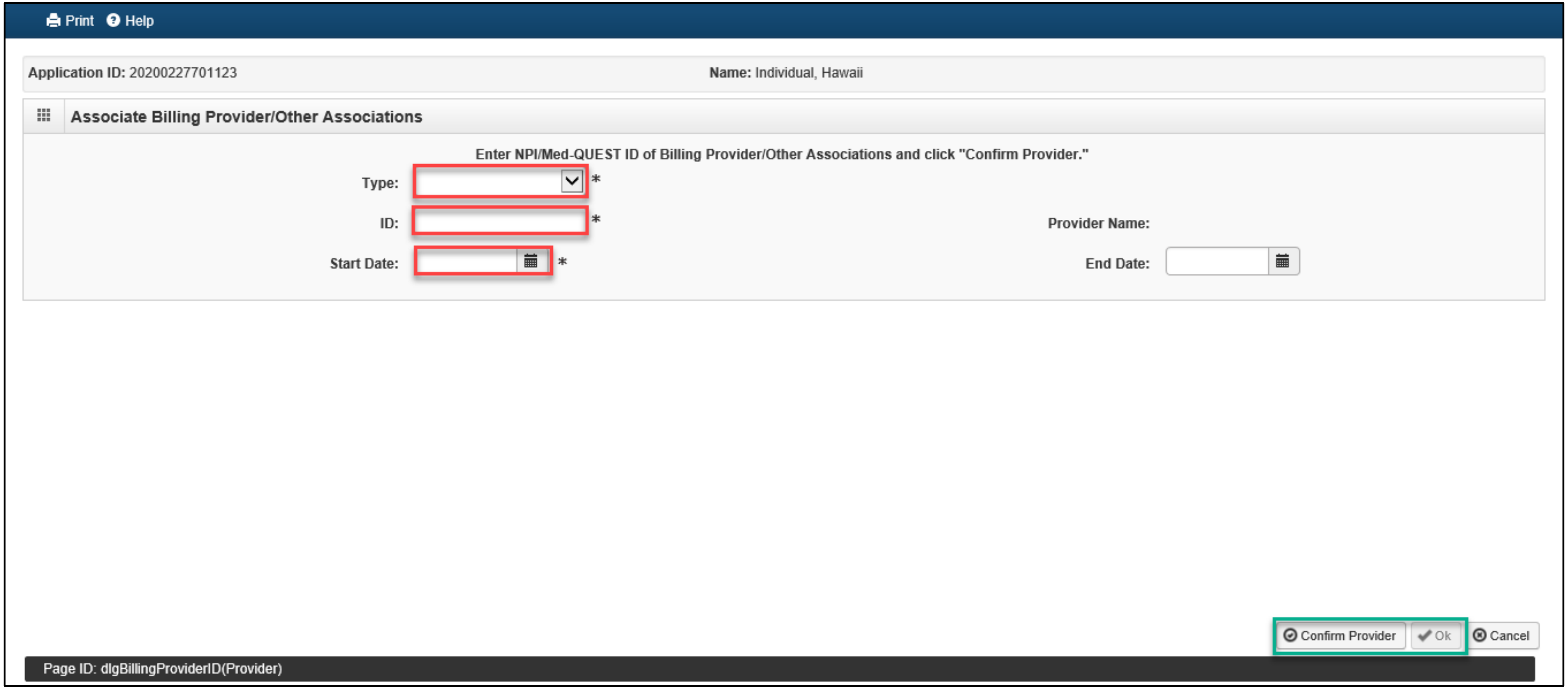
Application ID: 20200227701123 **Name:** Individual, Hawaii

☐	NPI/Med-QUEST ID	Provider Name	Start Date	End Date	Status
	No Records Found !				

Page ID: pgBillingProviderListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 09:53:38 MST

©2019 CNSI

Associate Billing Provider


Print
Help
Confirm Provider
Ok
Cancel

Application ID: 20200227701123

Name: Individual, Hawaii

Associate Billing Provider/Other Associations

Enter NPI/Med-QUEST ID of Billing Provider/Other Associations and click "Confirm Provider."

Type: *

ID: *

Provider Name:

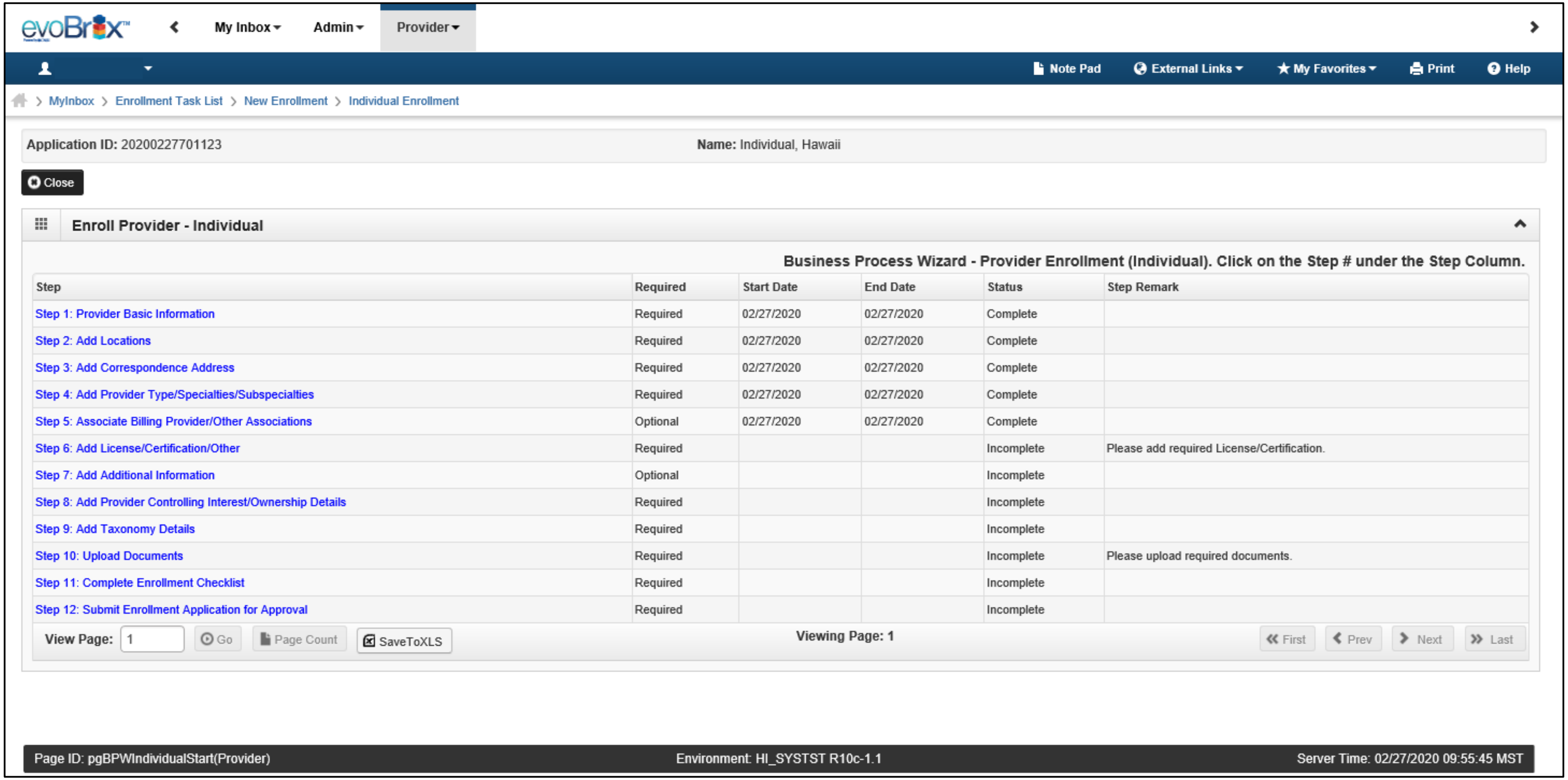
Start Date: *

End Date:

Page ID: dlgBillingProviderID(Provider)

©2019 CNSI

Step 6: Add License/Certification


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close

Application ID: 20200227701123

Name: Individual, Hawaii

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

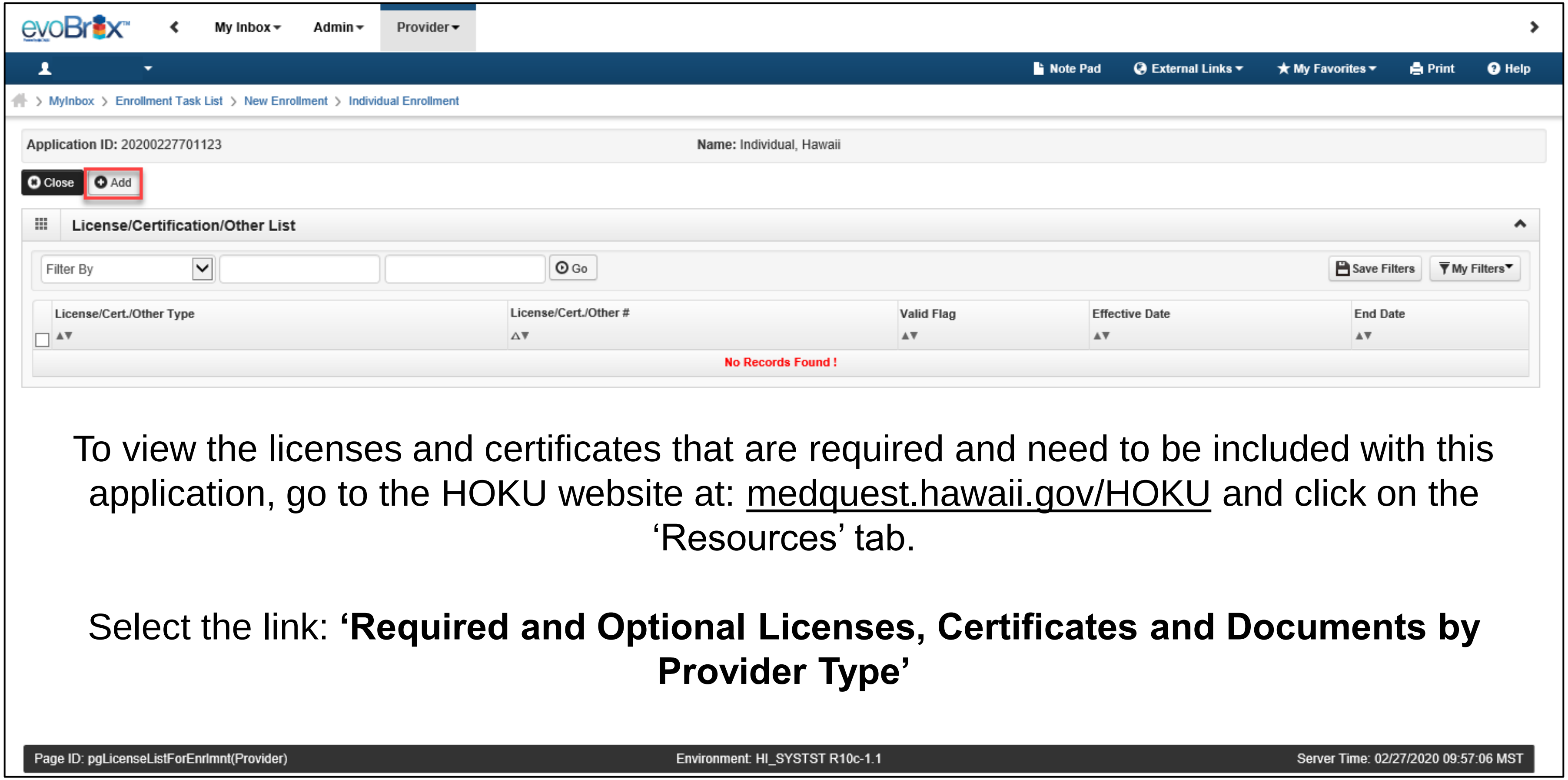
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/27/2020	02/27/2020	Complete	
Step 2: Add Locations	Required	02/27/2020	02/27/2020	Complete	
Step 3: Add Correspondence Address	Required	02/27/2020	02/27/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/27/2020	02/27/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/27/2020	02/27/2020	Complete	
Step 6: Add License/Certification/Other	Required			Incomplete	Please add required License/Certification.
Step 7: Add Additional Information	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Upload Documents	Required			Incomplete	Please upload required documents.
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1
Go
Page Count
SaveToXLS
Viewing Page: 1
First
Prev
Next
Last

Page ID: pgBPWIndividualStart(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/27/2020 09:55:45 MST

©2019 CNSI

Add License/Certification


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Add
Filter By
Go
Save Filters
My Filters

Application ID: 20200227701123

Name: Individual, Hawaii

License/Certification/Other List

☐	License/Cert./Other Type	License/Cert./Other #	Valid Flag	Effective Date	End Date
			No Records Found !		

Page ID: pgLicenseListForEnrlmnt(Provider)

Environment: HI_SYSTST R10c-1.1

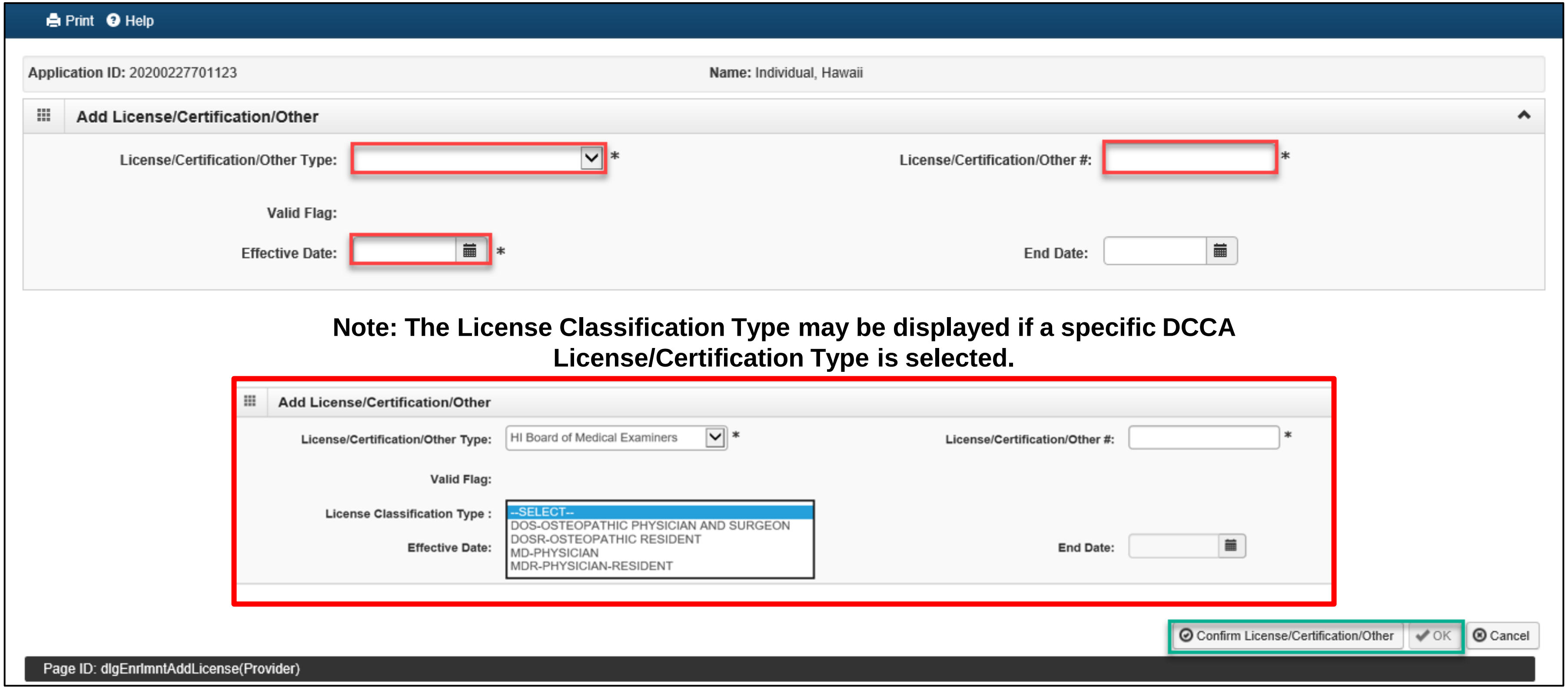
Server Time: 02/27/2020 09:57:06 MST

To view the licenses and certificates that are required and need to be included with this application, go to the HOKU website at: medquest.hawaii.gov/HOKU and click on the ‘Resources’ tab.

Select the link: **‘Required and Optional Licenses, Certificates and Documents by Provider Type’**

©2019 CNSI

Add License/Certification



Application ID: 20200227701123
Name: Individual, Hawaii

Add License/Certification/Other

License/Certification/Other Type: *
License/Certification/Other #: *
Valid Flag:
Effective Date: *
End Date:

Note: The License Classification Type may be displayed if a specific DCCA License/Certification Type is selected.

Add License/Certification/Other

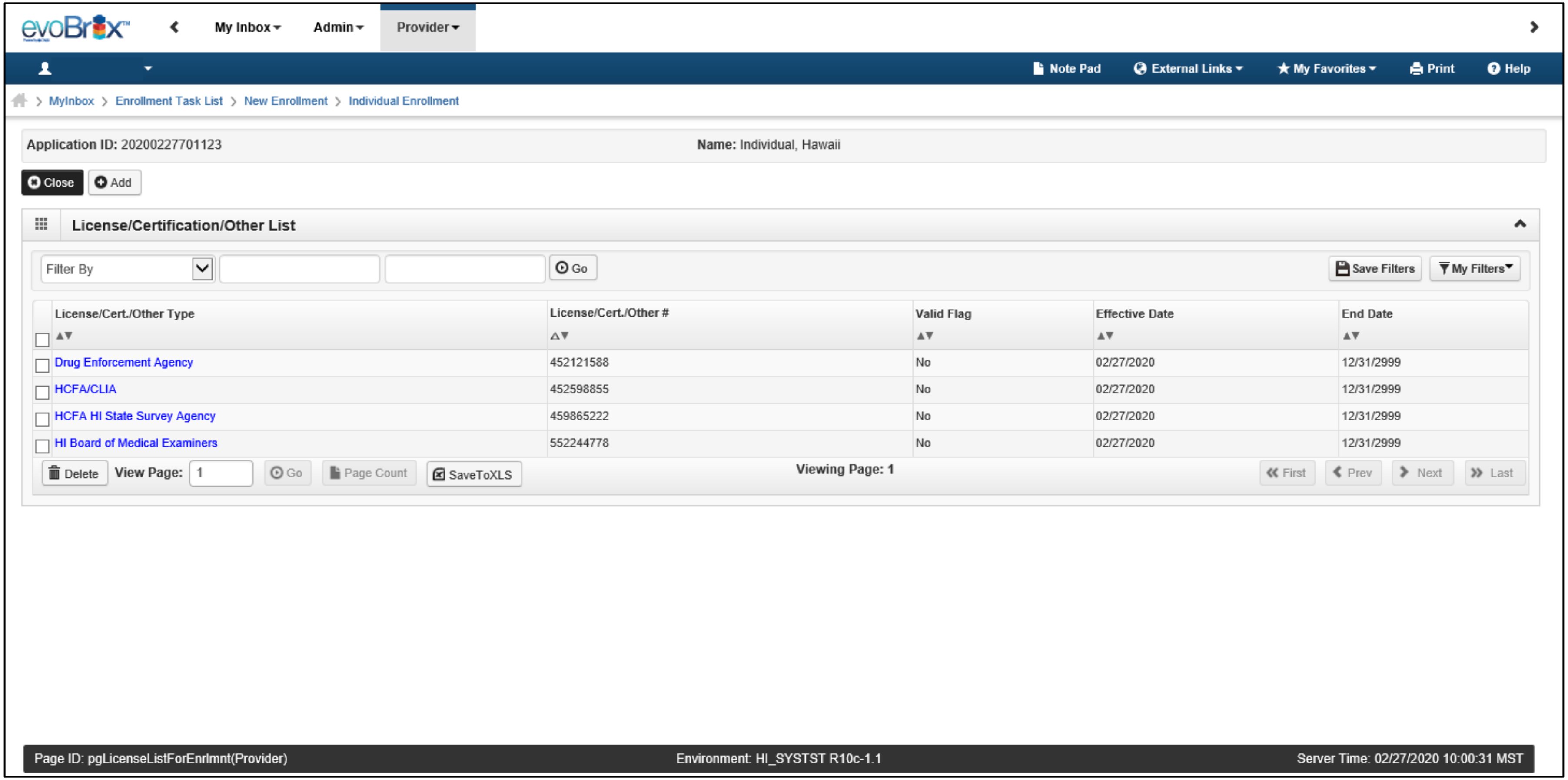
License/Certification/Other Type: HI Board of Medical Examiners *
License/Certification/Other #: *
Valid Flag:
License Classification Type :
- --SELECT--
- DOS-OSTEOPATHIC PHYSICIAN AND SURGEON
- DOSR-OSTEOPATHIC RESIDENT
- MD-PHYSICIAN
- MDR-PHYSICIAN-RESIDENT

Effective Date:
End Date:

Page ID: dlgEnrlmntAddLicense(Provider)

©2019 CNSI

Add License/Certification


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Add
Filter By
Go
Save Filters
My Filters
Delete
Go
Page Count
SaveToXLS
First
Prev
Next
Last

Application ID: 20200227701123

Name: Individual, Hawaii

License/Certification/Other List

☐	License/Cert./Other Type	License/Cert./Other #	Valid Flag	Effective Date	End Date
☐	Drug Enforcement Agency	452121588	No	02/27/2020	12/31/2999
☐	HCFA/CLIA	452598855	No	02/27/2020	12/31/2999
☐	HCFA HI State Survey Agency	459865222	No	02/27/2020	12/31/2999
☐	HI Board of Medical Examiners	552244778	No	02/27/2020	12/31/2999

View Page: 1

Viewing Page: 1

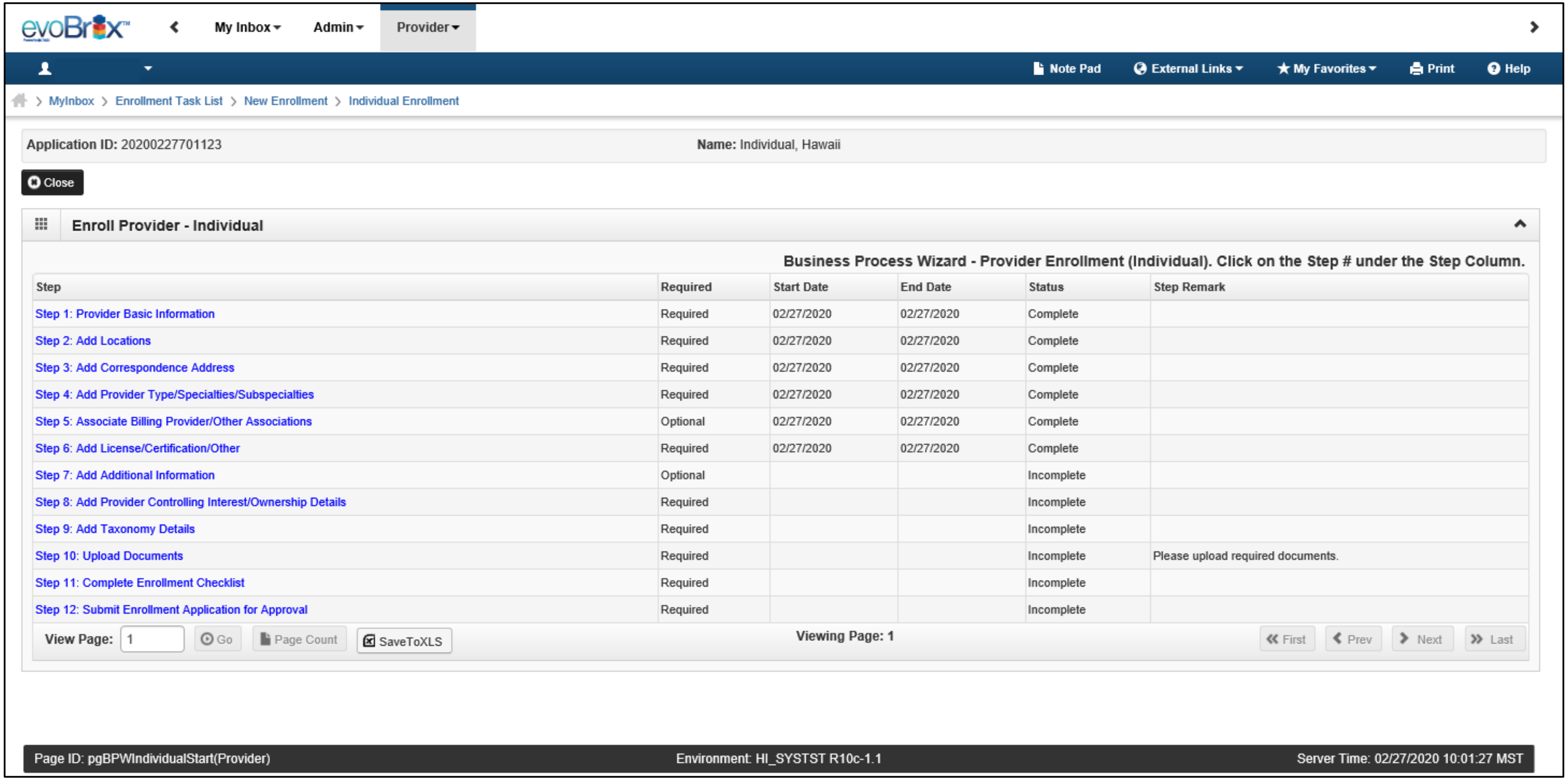
Page ID: pgLicenseListForEnrlmnt(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/27/2020 10:00:31 MST

©2019 CNSI

Step 7: Add Additional Information


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
First
Prev
Next
Last
Go
Page Count
SaveToXLS

Application ID: 20200227701123

Name: Individual, Hawaii

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/27/2020	02/27/2020	Complete	
Step 2: Add Locations	Required	02/27/2020	02/27/2020	Complete	
Step 3: Add Correspondence Address	Required	02/27/2020	02/27/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/27/2020	02/27/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/27/2020	02/27/2020	Complete	
Step 6: Add License/Certification/Other	Required	02/27/2020	02/27/2020	Complete	
Step 7: Add Additional Information	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Upload Documents	Required			Incomplete	Please upload required documents.
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

Viewing Page: 1

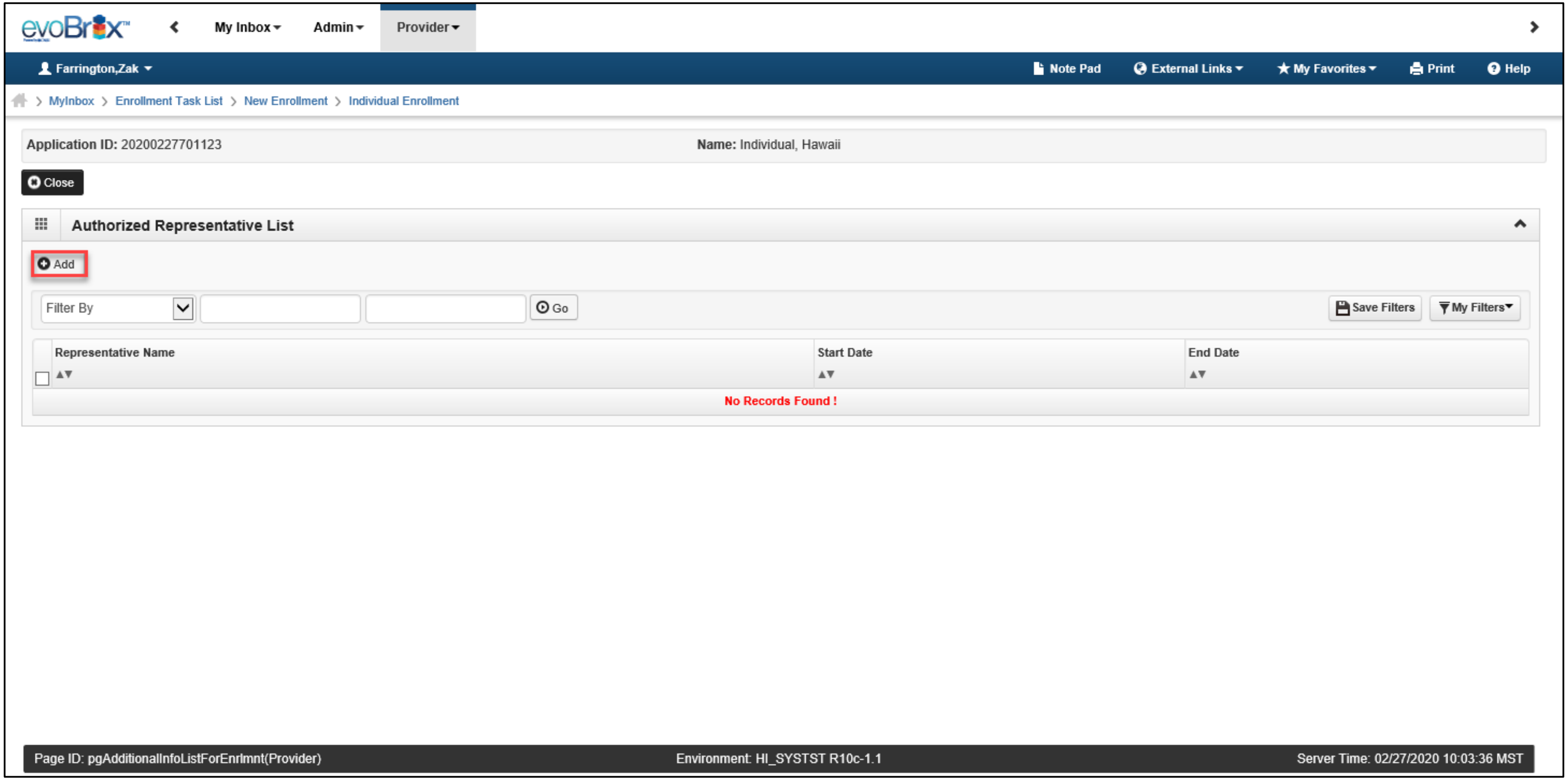
Page ID: pgBPWIndividualStart(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/27/2020 10:01:27 MST

©2019 CNSI

Add Additional Information


evoBrix
My Inbox
Admin
Provider
Farrington,Zak
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Add
Filter By
Go
Save Filters
My Filters

Application ID: 20200227701123 **Name:** Individual, Hawaii

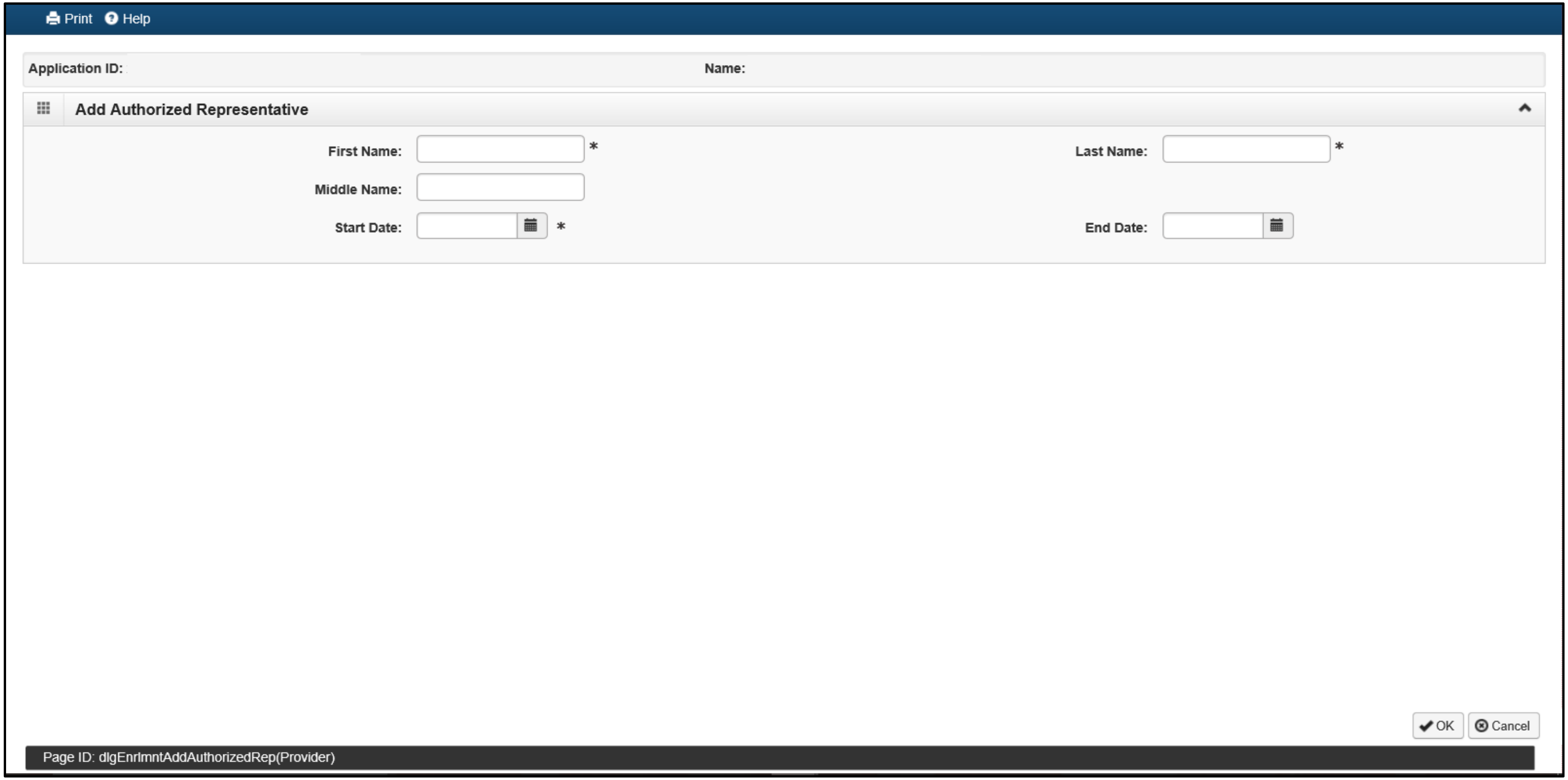
Authorized Representative List

☐	Representative Name	Start Date	End Date
	No Records Found !		

Page ID: pgAdditionalInfoListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 10:03:36 MST

©2019 CNSI

Add Additional Information



Application ID: **Name:**

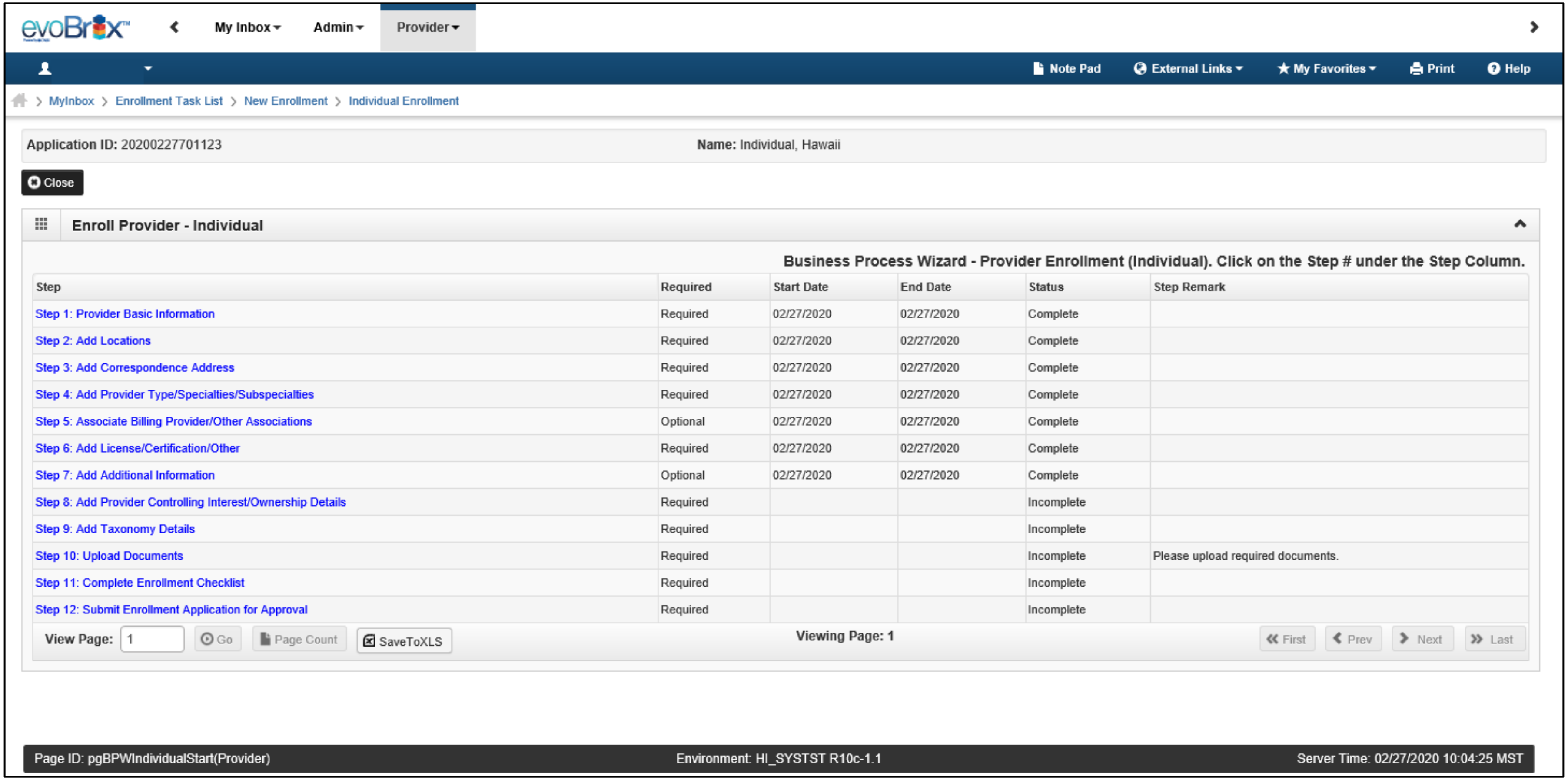
Add Authorized Representative

First Name:	*	**Last Name:**	*
Middle Name:			
Start Date:	*	**End Date:**	

Page ID: dlgEnrlmntAddAuthorizedRep(Provider)

©2019 CNSI

Step 8: Controlling Interest/Ownership Details


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close

Application ID: 20200227701123

Name: Individual, Hawaii

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/27/2020	02/27/2020	Complete	
Step 2: Add Locations	Required	02/27/2020	02/27/2020	Complete	
Step 3: Add Correspondence Address	Required	02/27/2020	02/27/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/27/2020	02/27/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/27/2020	02/27/2020	Complete	
Step 6: Add License/Certification/Other	Required	02/27/2020	02/27/2020	Complete	
Step 7: Add Additional Information	Optional	02/27/2020	02/27/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Upload Documents	Required			Incomplete	Please upload required documents.
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

Go
Page Count
SaveToXLS
First
Prev
Next
Last

Viewing Page: 1

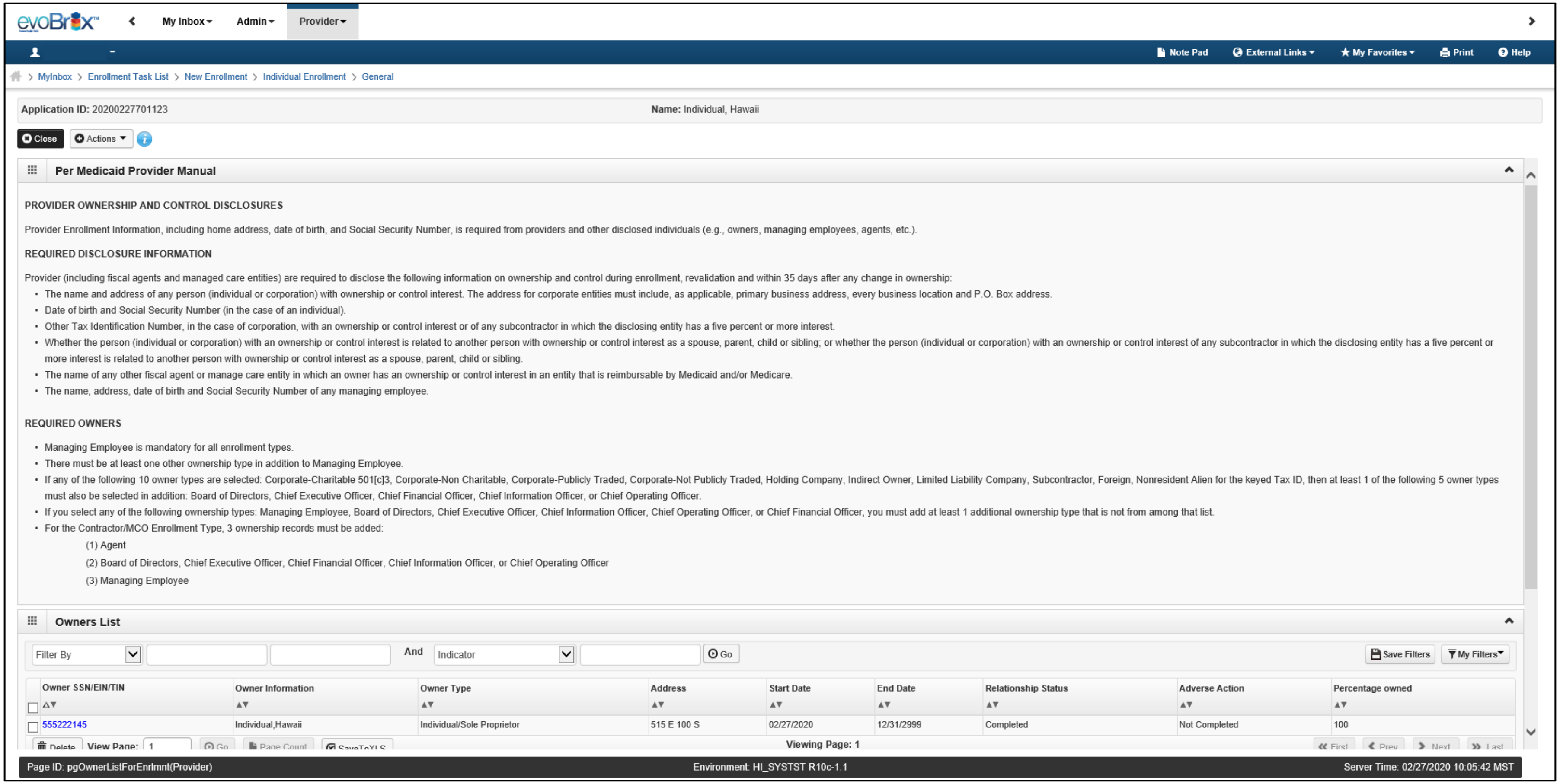
Page ID: pgBPWIndividualStart(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/27/2020 10:04:25 MST

©2019 CNSI

Add Controlling Interest/Ownership Details



evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment > General

Application ID: 20200227701123 **Name:** Individual, Hawaii

Per Medicaid Provider Manual

PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 10 owner types are selected: Corporate-Charitable 501[c]3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the keyed Tax ID, then at least 1 of the following 5 owner types must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer.
- If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Officer, or Chief Financial Officer, you must add at least 1 additional ownership type that is not from among that list.
- For the Contractor/MCO Enrollment Type, 3 ownership records must be added:
  - (1) Agent
  - (2) Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer
  - (3) Managing Employee

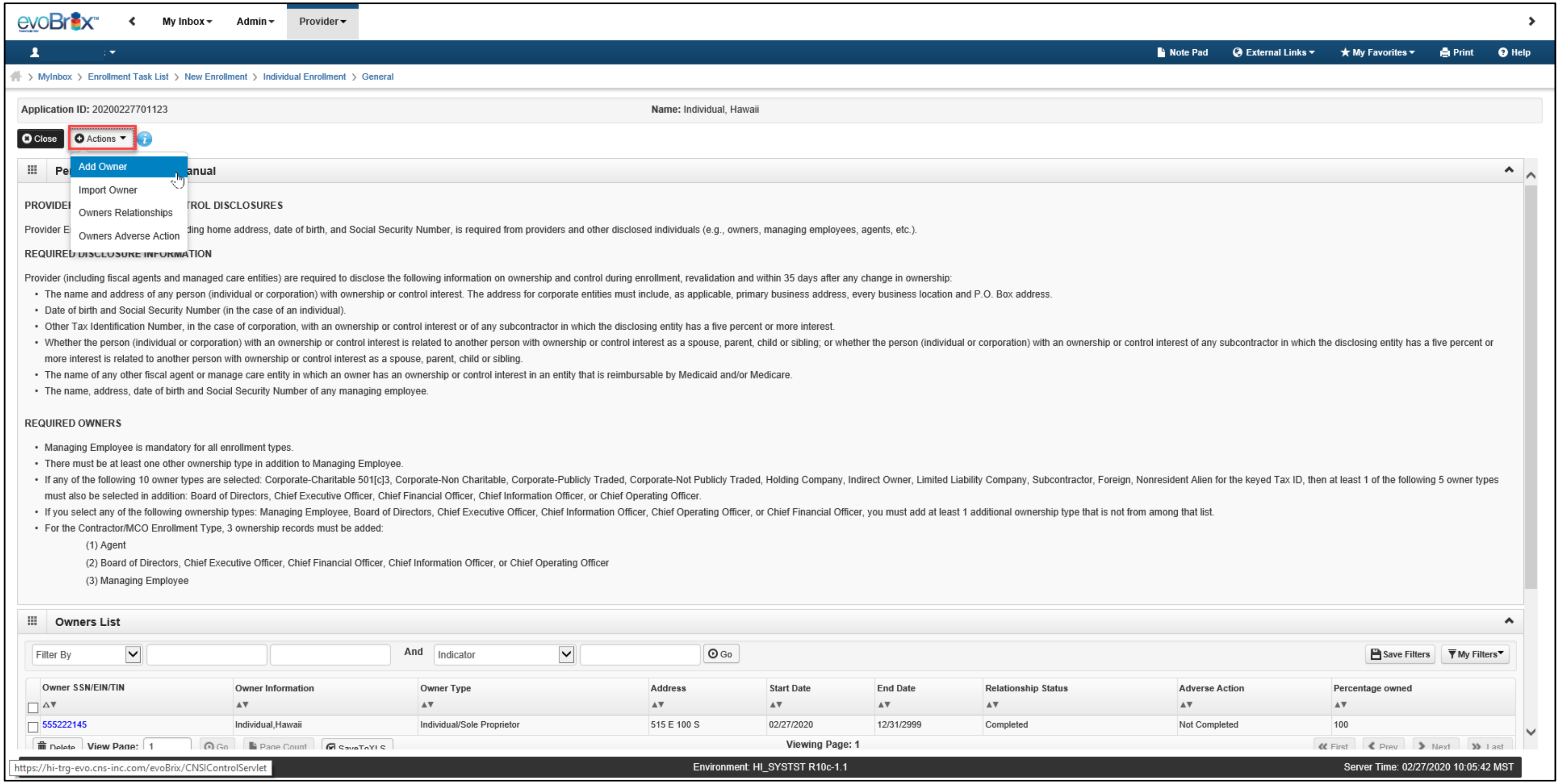
Owners List

☐	Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
☐	555222145	Individual,Hawaii	Individual/Sole Proprietor	515 E 100 S	02/27/2020	12/31/2999	Completed	Not Completed	100

Page ID: pgOwnerListForEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 10:05:42 MST

©2019 CNSI

Add Owner



Application ID: 20200227701123 **Name:** Individual, Hawaii

Pe anual

PROVIDER TROL DISCLOSURES

Provider E ding home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 10 owner types are selected: Corporate-Charitable 501[c]3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the keyed Tax ID, then at least 1 of the following 5 owner types must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer.
- If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Officer, or Chief Financial Officer, you must add at least 1 additional ownership type that is not from among that list.
- For the Contractor/MCO Enrollment Type, 3 ownership records must be added:
  - (1) Agent
  - (2) Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer
  - (3) Managing Employee

Owners List

☐	Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
☐	555222145	Individual,Hawaii	Individual/Sole Proprietor	515 E 100 S	02/27/2020	12/31/2999	Completed	Not Completed	100

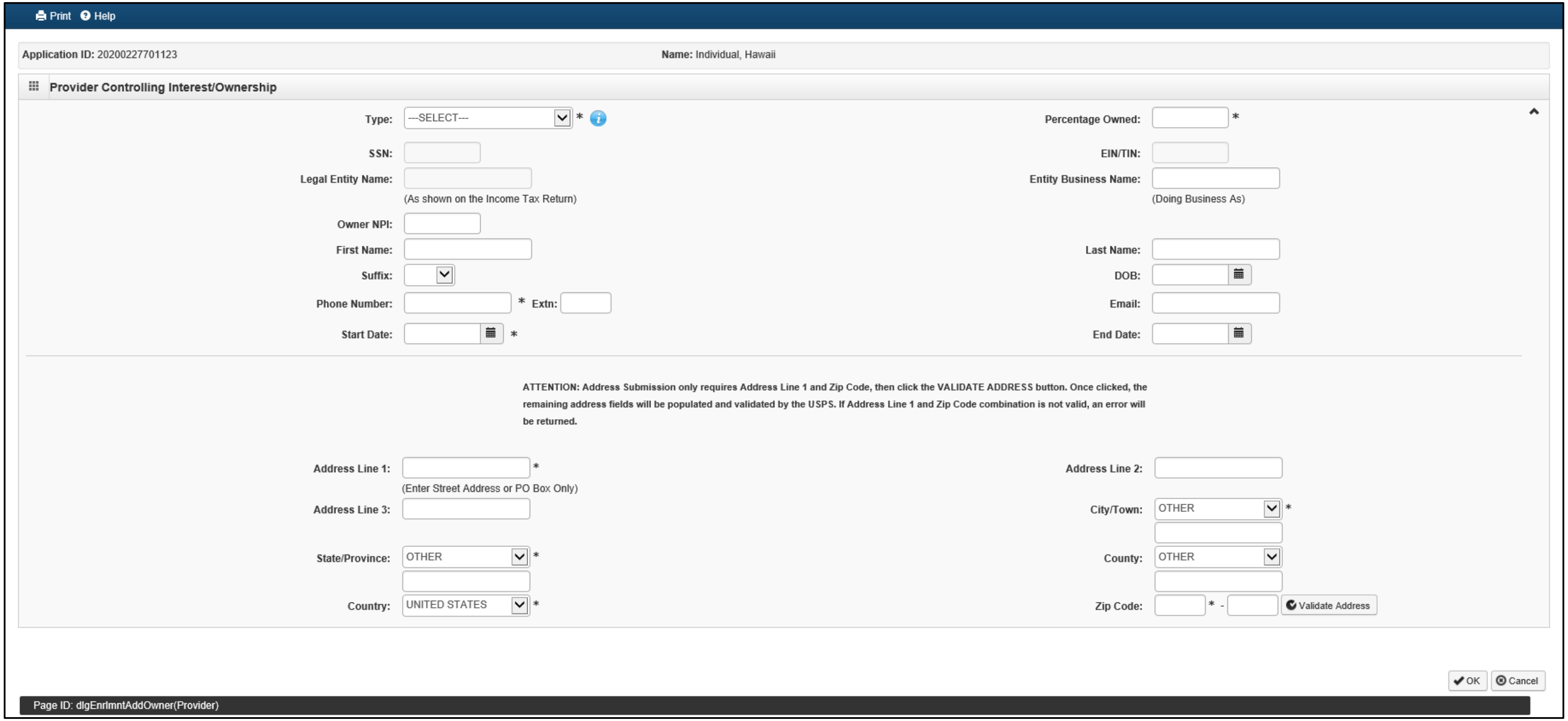
https://hi-trg-evo.cns-inc.com/evoBrix/CNSIControlServlet

Environment: HI_SYSTST R10c-1.1

Server Time: 02/27/2020 10:05:42 MST

©2019 CNSI

Add Ownership



Application ID: 20200227701123
Name: Individual, Hawaii

Provider Controlling Interest/Ownership

Type:	---SELECT--- *	Percentage Owned:	*
SSN:		EIN/TIN:	
Legal Entity Name:	(As shown on the Income Tax Return)	Entity Business Name:	(Doing Business As)
Owner NPI:			
First Name:		Last Name:	
Suffix:		DOB:	
Phone Number:	* Extn:	Email:	
Start Date:	*	End Date:	

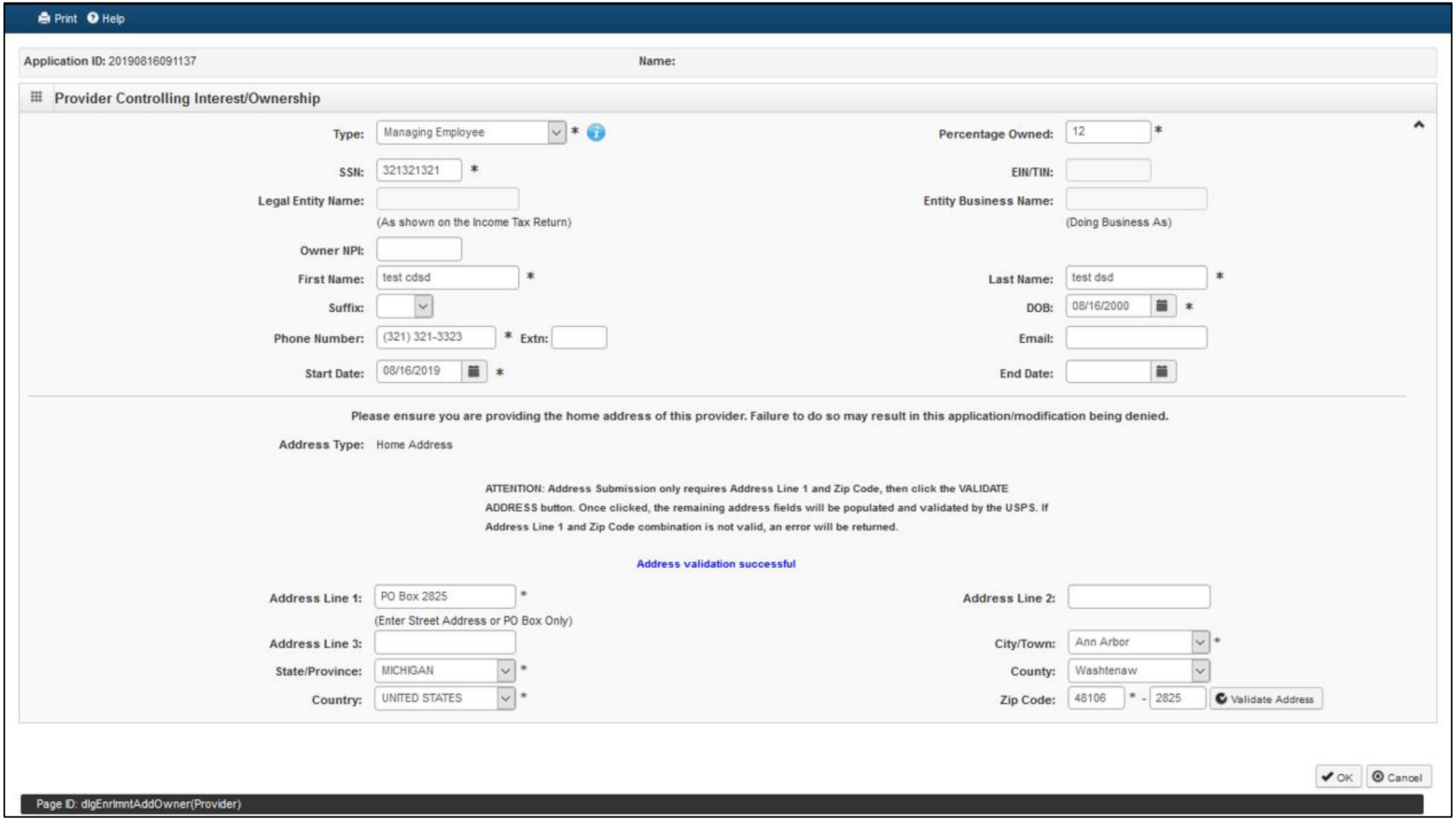
ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address Line 1:	* (Enter Street Address or PO Box Only)	Address Line 2:	
Address Line 3:		City/Town:	OTHER *
State/Province:	OTHER *	County:	OTHER
Country:	UNITED STATES *	Zip Code:	* -

Page ID: dlgEnrlmntAddOwner(Provider)

©2019 CNSI

Add Ownership



Application ID: 20190816091137

Name:

Provider Controlling Interest/Ownership

Type:	Managing Employee *	**Percentage Owned:**	12 *
SSN:	321321321 *	**EIN/TIN:**	
Legal Entity Name:	(As shown on the Income Tax Return)	**Entity Business Name:**	(Doing Business As)
Owner NPI:			
First Name:	test cdsd *	**Last Name:**	test dsd *
Suffix:		**DOB:**	08/16/2000 *
Phone Number:	(321) 321-3323 * **Extn:**	**Email:**	
Start Date:	08/16/2019 *	**End Date:**	

Please ensure you are providing the home address of this provider. Failure to do so may result in this application/modification being denied.

Address Type: Home Address

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

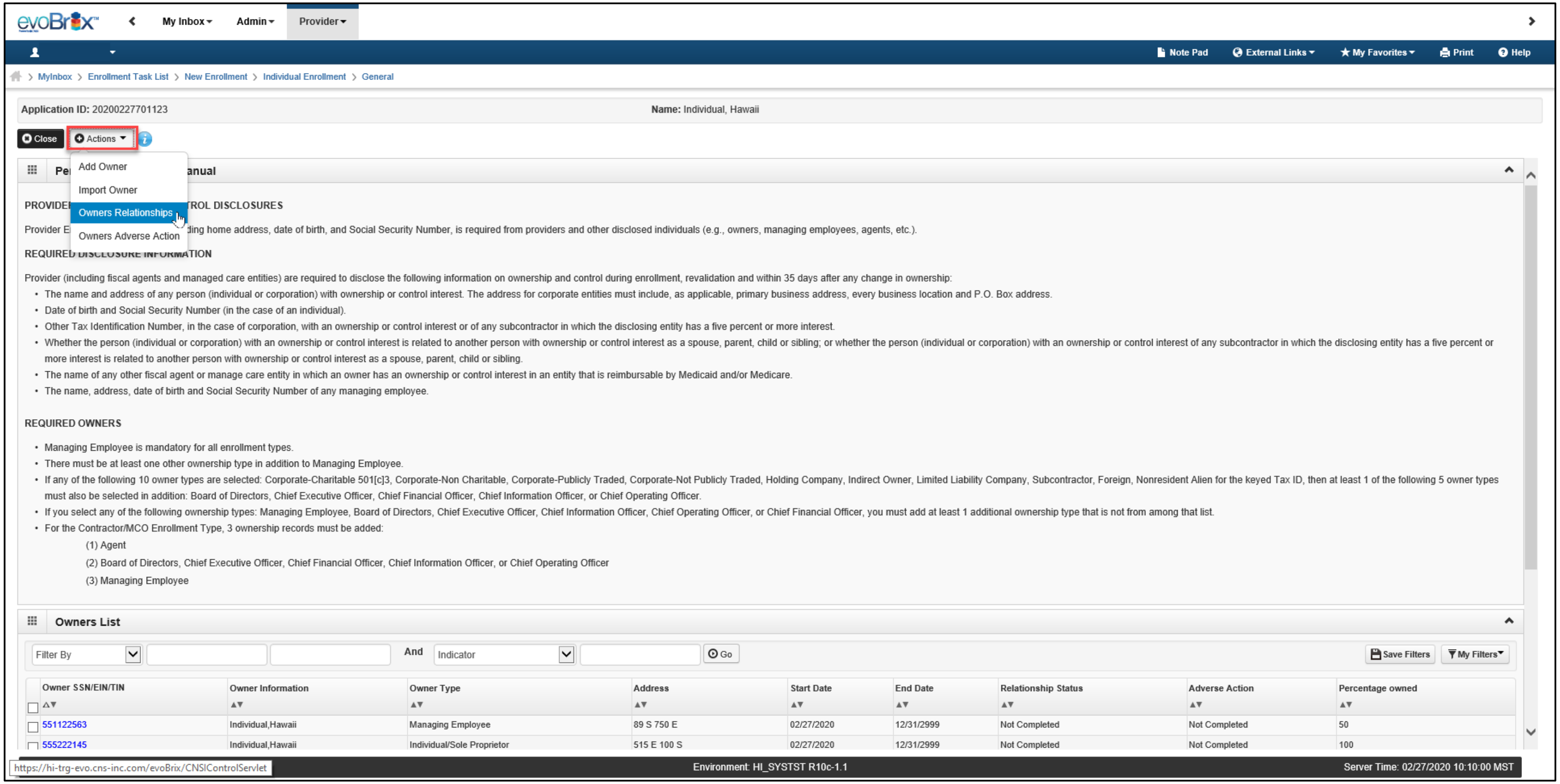
Address validation successful

Address Line 1:	PO Box 2825 * (Enter Street Address or PO Box Only)	**Address Line 2:**	
Address Line 3:		**City/Town:**	Ann Arbor *
State/Province:	MICHIGAN *	**County:**	Washtenaw
Country:	UNITED STATES *	**Zip Code:**	48106 * - 2825

Page ID: dlgEnrlmntAddOwner(Provider)

©2019 CNSI

Add Owners Relationship



MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment > General

Application ID: 20200227701123 **Name:** Individual, Hawaii

Pe… anual

PROVIDE… …ROL DISCLOSURES

Provider E… …ding home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 10 owner types are selected: Corporate-Charitable 501[c]3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the keyed Tax ID, then at least 1 of the following 5 owner types must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer.
- If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Officer, or Chief Financial Officer, you must add at least 1 additional ownership type that is not from among that list.
- For the Contractor/MCO Enrollment Type, 3 ownership records must be added:
  - (1) Agent
  - (2) Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer
  - (3) Managing Employee

Owners List

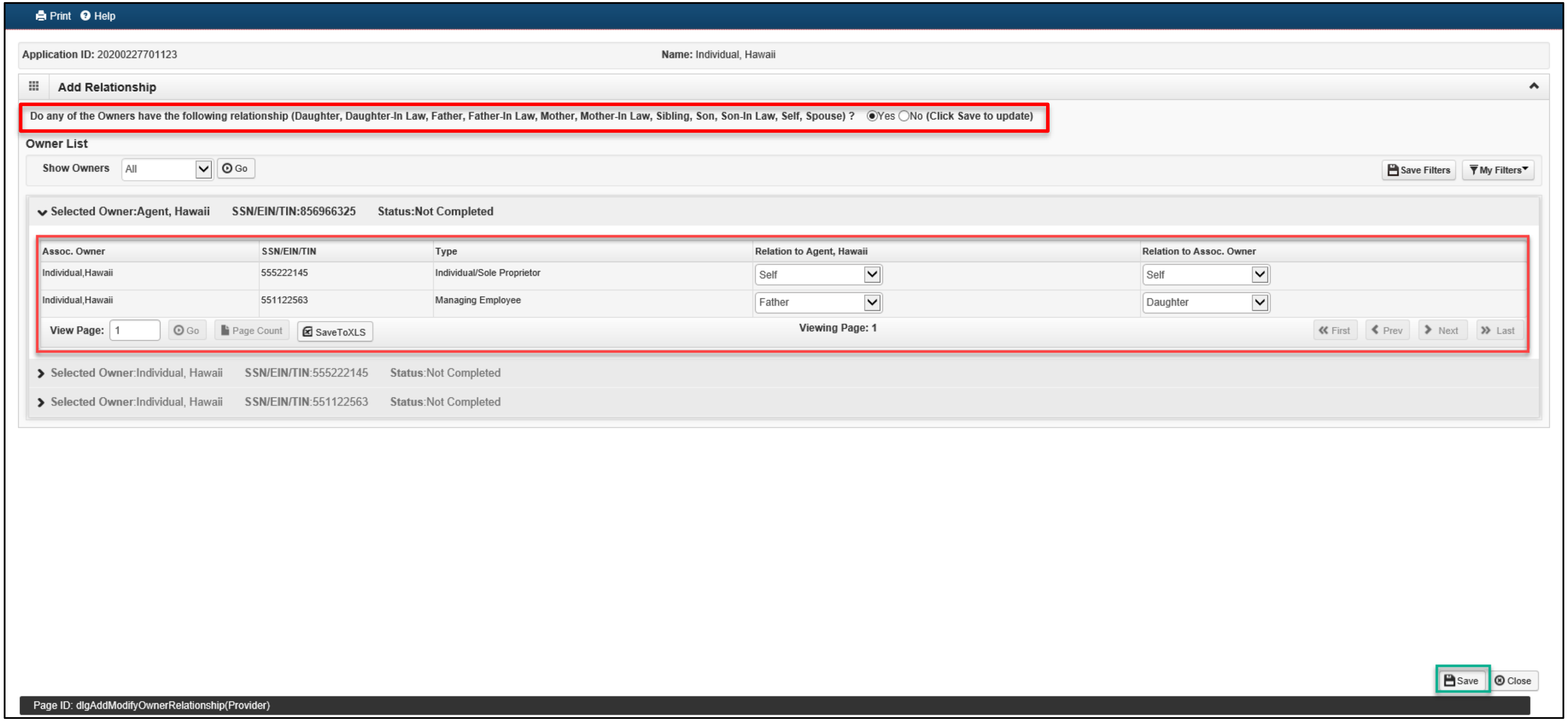
	Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
☐	551122563	Individual,Hawaii	Managing Employee	89 S 750 E	02/27/2020	12/31/2999	Not Completed	Not Completed	50
☐	555222145	Individual,Hawaii	Individual/Sole Proprietor	515 E 100 S	02/27/2020	12/31/2999	Not Completed	Not Completed	100

Environment: HI_SYSTST R10c-1.1

Server Time: 02/27/2020 10:10:00 MST

©2019 CNSI

Add Owners Relationship



Application ID: 20200227701123

Name: Individual, Hawaii

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ● Yes ○ No (Click Save to update)

Owner List

Show Owners All

Selected Owner: Agent, Hawaii **SSN/EIN/TIN:** 856966325 **Status:** Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Agent, Hawaii	Relation to Assoc. Owner
Individual,Hawaii	555222145	Individual/Sole Proprietor	Self	Self
Individual,Hawaii	551122563	Managing Employee	Father	Daughter

View Page: 1

Viewing Page: 1

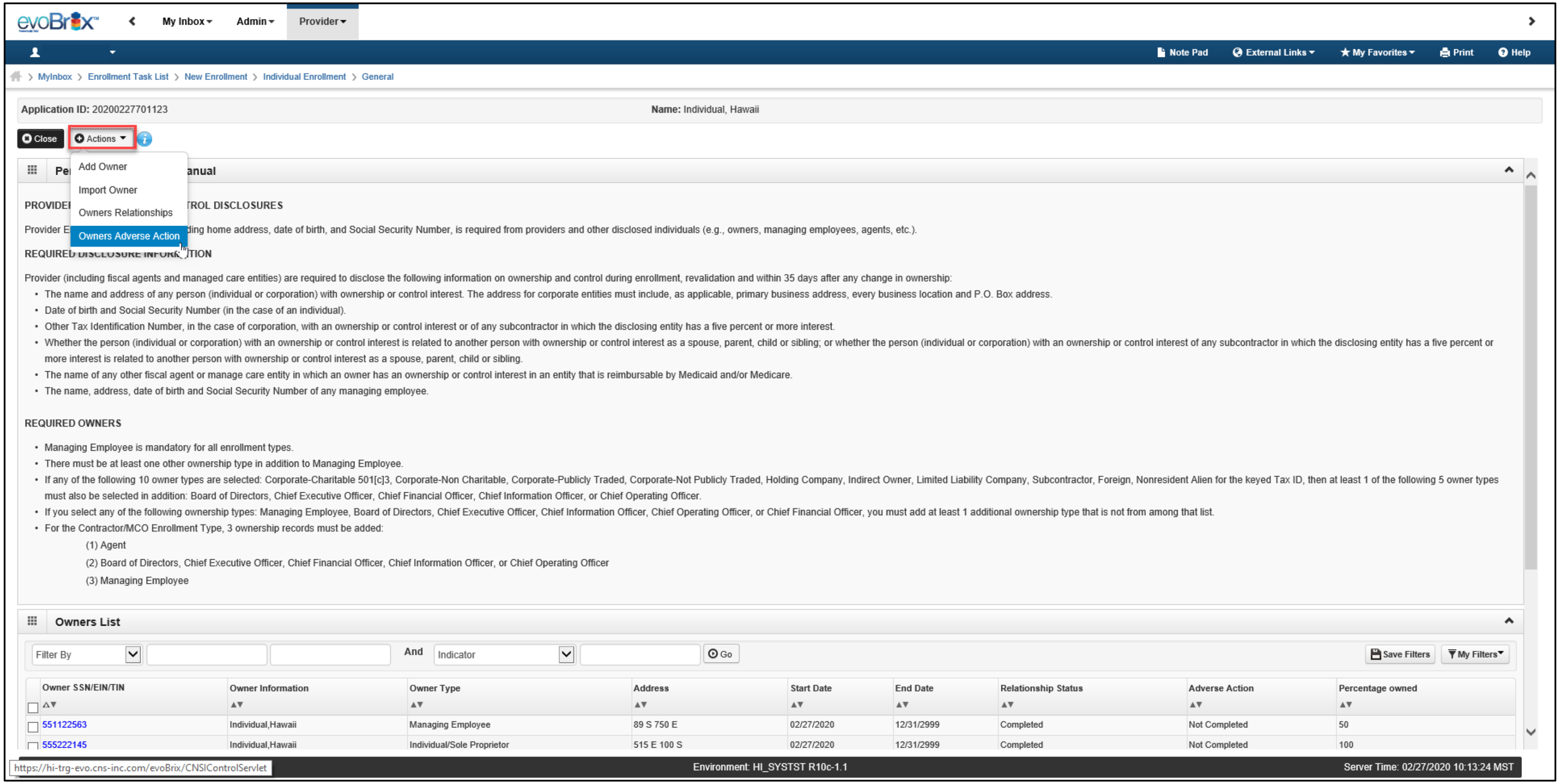
Selected Owner: Individual, Hawaii **SSN/EIN/TIN:** 555222145 **Status:** Not Completed

Selected Owner: Individual, Hawaii **SSN/EIN/TIN:** 551122563 **Status:** Not Completed

Page ID: dlgAddModifyOwnerRelationship(Provider)

©2019 CNSI

Complete Adverse Actions



Application ID: 20200227701123 **Name:** Individual, Hawaii

Pe anual

PROVIDE TROL DISCLOSURES

Provider E ding home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFOR TION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 10 owner types are selected: Corporate-Charitable 501[c]3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the keyed Tax ID, then at least 1 of the following 5 owner types must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer.
- If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Officer, or Chief Financial Officer, you must add at least 1 additional ownership type that is not from among that list.
- For the Contractor/MCO Enrollment Type, 3 ownership records must be added:
  (1) Agent
  (2) Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer
  (3) Managing Employee

Owners List

☐	Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
☐	551122563	Individual,Hawaii	Managing Employee	89 S 750 E	02/27/2020	12/31/2999	Completed	Not Completed	50
☐	555222145	Individual,Hawaii	Individual/Sole Proprietor	515 E 100 S	02/27/2020	12/31/2999	Completed	Not Completed	100

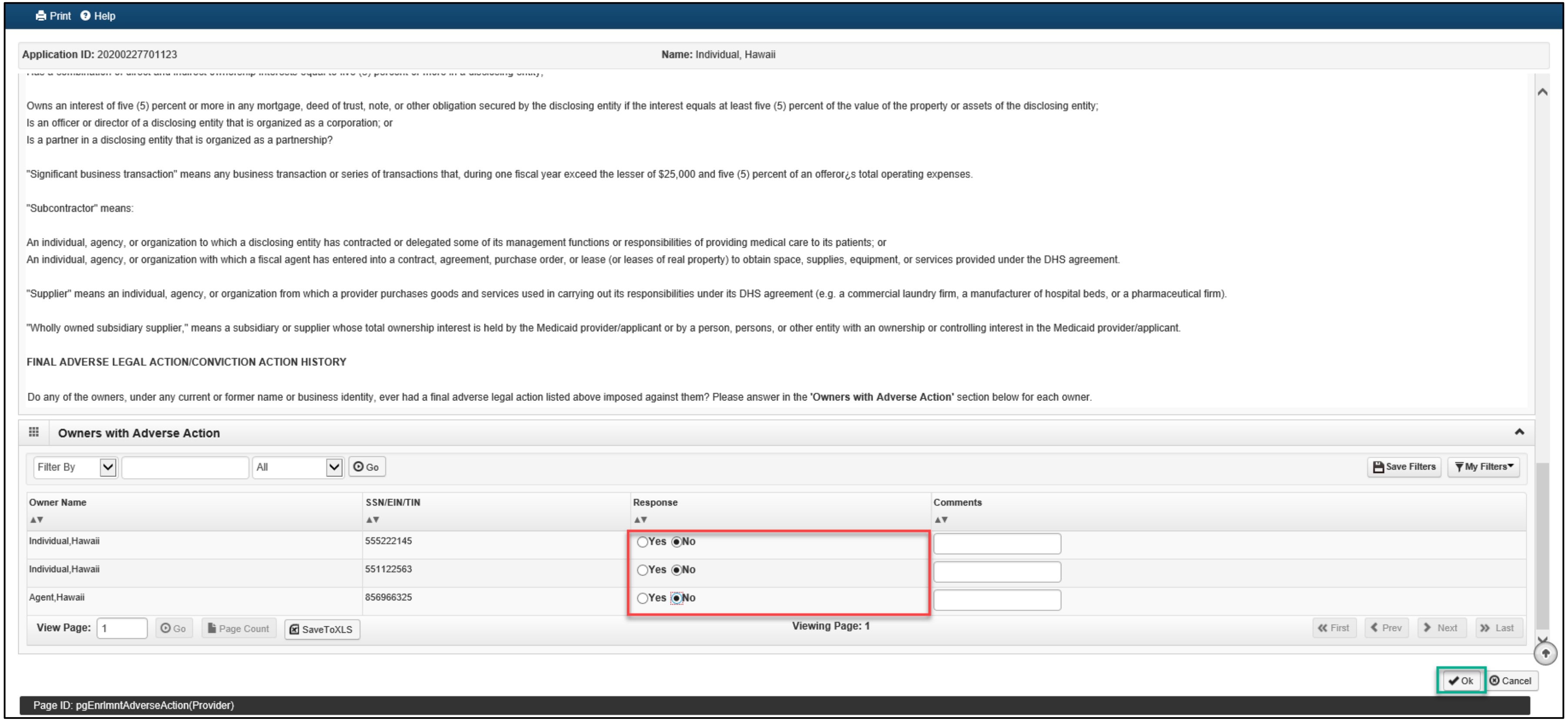
https://hi-trg-evo.cns-inc.com/evoBrix/CNSIControlServlet

Environment: HI_SYSTST R10c-1.1

Server Time: 02/27/2020 10:13:24 MST

©2019 CNSI

Disclose Adverse Actions



Application ID: 20200227701123 **Name:** Individual, Hawaii

Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if the interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;
Is an officer or director of a disclosing entity that is organized as a corporation; or
Is a partner in a disclosing entity that is organized as a partnership?

"Significant business transaction" means any business transaction or series of transactions that, during one fiscal year exceed the lesser of $25,000 and five (5) percent of an offeror¿s total operating expenses.

"Subcontractor" means:

An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the DHS agreement.

"Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under its DHS agreement (e.g. a commercial laundry firm, a manufacturer of hospital beds, or a pharmaceutical firm).

"Wholly owned subsidiary supplier," means a subsidiary or supplier whose total ownership interest is held by the Medicaid provider/applicant or by a person, persons, or other entity with an ownership or controlling interest in the Medicaid provider/applicant.

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against them? Please answer in the **'Owners with Adverse Action'** section below for each owner.

Owners with Adverse Action

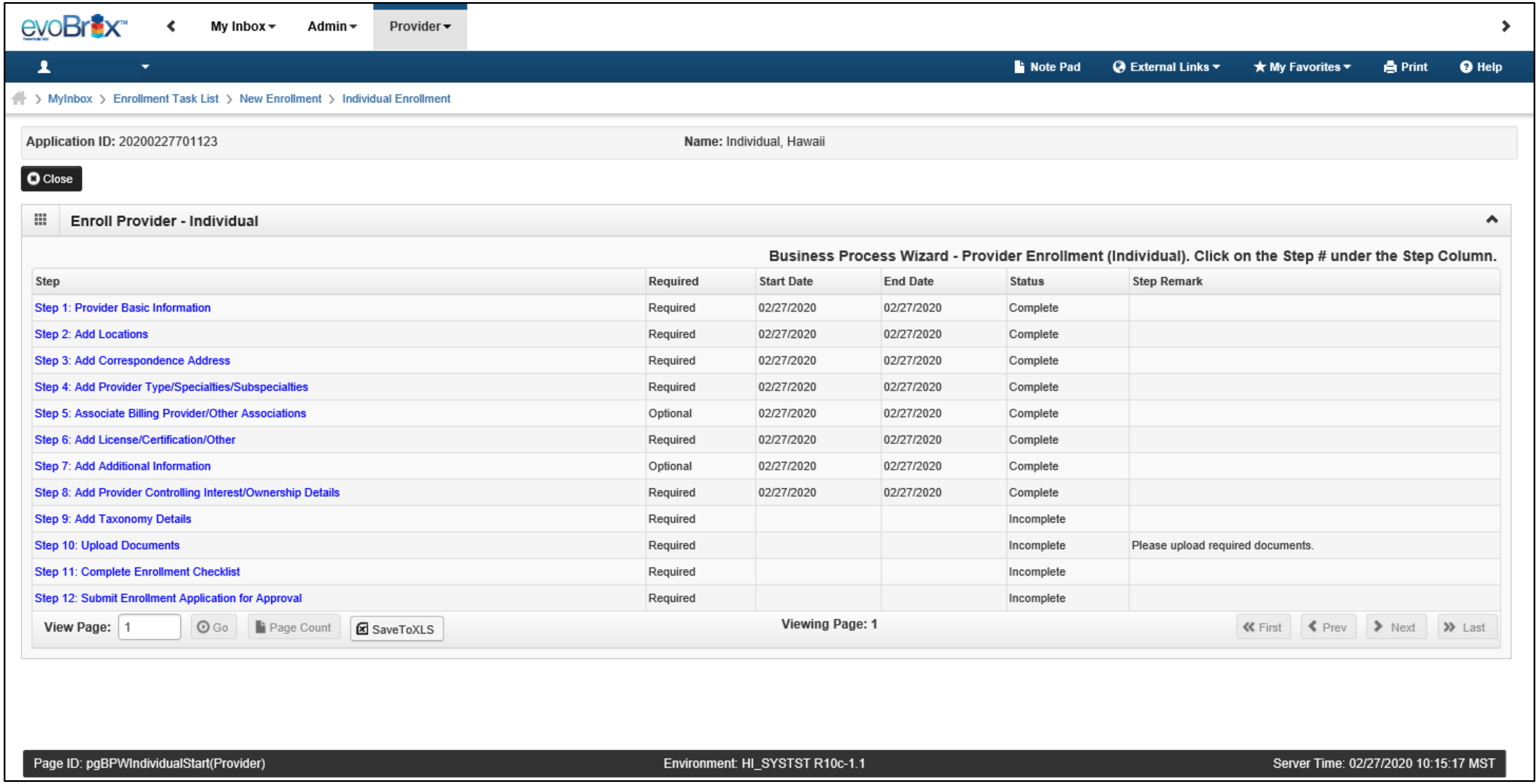
Owner Name	SSN/EIN/TIN	Response	Comments
Individual,Hawaii	555222145	○ Yes ● No	
Individual,Hawaii	551122563	○ Yes ● No	
Agent,Hawaii	856966325	○ Yes ● No	

View Page: 1 **Viewing Page: 1**

Page ID: pgEnrlmntAdverseAction(Provider)

©2019 CNSI

Step 9: Taxonomy Details



MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment

Application ID: 20200227701123

Name: Individual, Hawaii

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/27/2020	02/27/2020	Complete	
Step 2: Add Locations	Required	02/27/2020	02/27/2020	Complete	
Step 3: Add Correspondence Address	Required	02/27/2020	02/27/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/27/2020	02/27/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/27/2020	02/27/2020	Complete	
Step 6: Add License/Certification/Other	Required	02/27/2020	02/27/2020	Complete	
Step 7: Add Additional Information	Optional	02/27/2020	02/27/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/27/2020	02/27/2020	Complete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Upload Documents	Required			Incomplete	Please upload required documents.
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

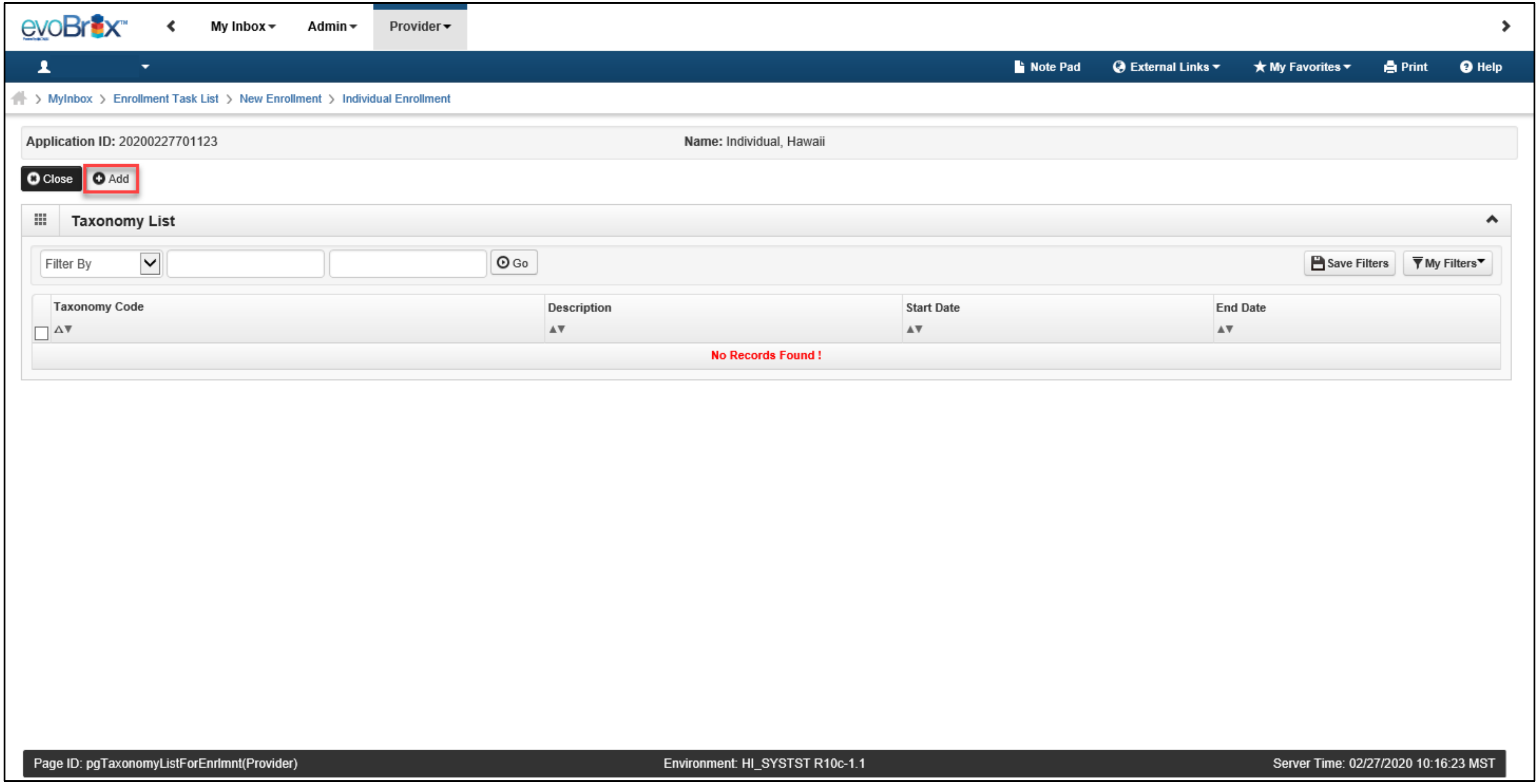
View Page: 1

Viewing Page: 1

Page ID: pgBPWIndividualStart(Provider)   Environment: HI_SYSTST R10c-1.1   Server Time: 02/27/2020 10:15:17 MST

©2019 CNSI

Add Taxonomy Details



evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment

Application ID: 20200227701123
Name: Individual, Hawaii

Close
Add

Taxonomy List

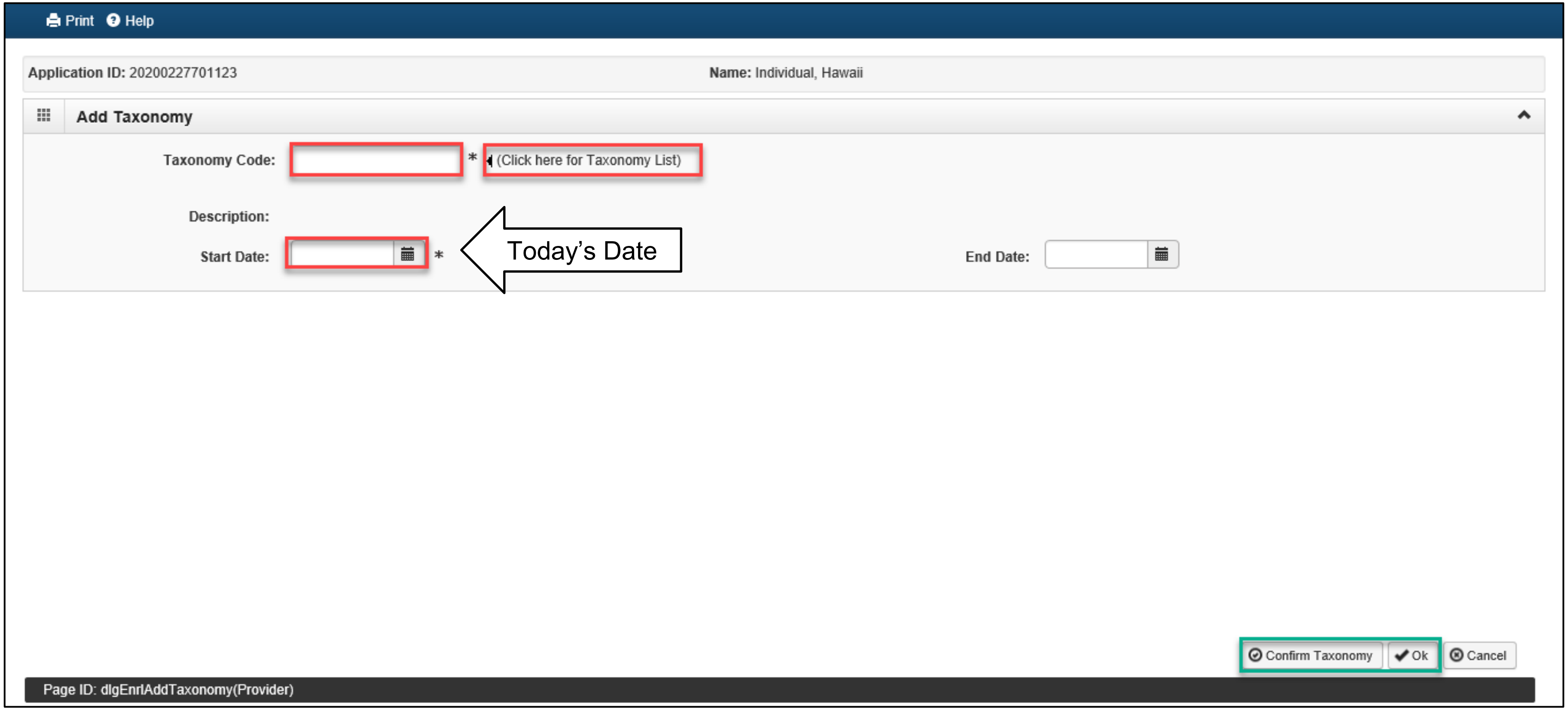
Filter By
Go
Save Filters
My Filters

☐	Taxonomy Code	Description	Start Date	End Date
	No Records Found !			

Page ID: pgTaxonomyListForEnrlmnt(Provider)
Environment: HI_SYSTST R10c-1.1
Server Time: 02/27/2020 10:16:23 MST

©2019 CNSI

Add Taxonomy


Print
Help

Application ID: 20200227701123

Name: Individual, Hawaii

Add Taxonomy

Taxonomy Code: * (Click here for Taxonomy List)

Description:

Start Date: *

Today's Date

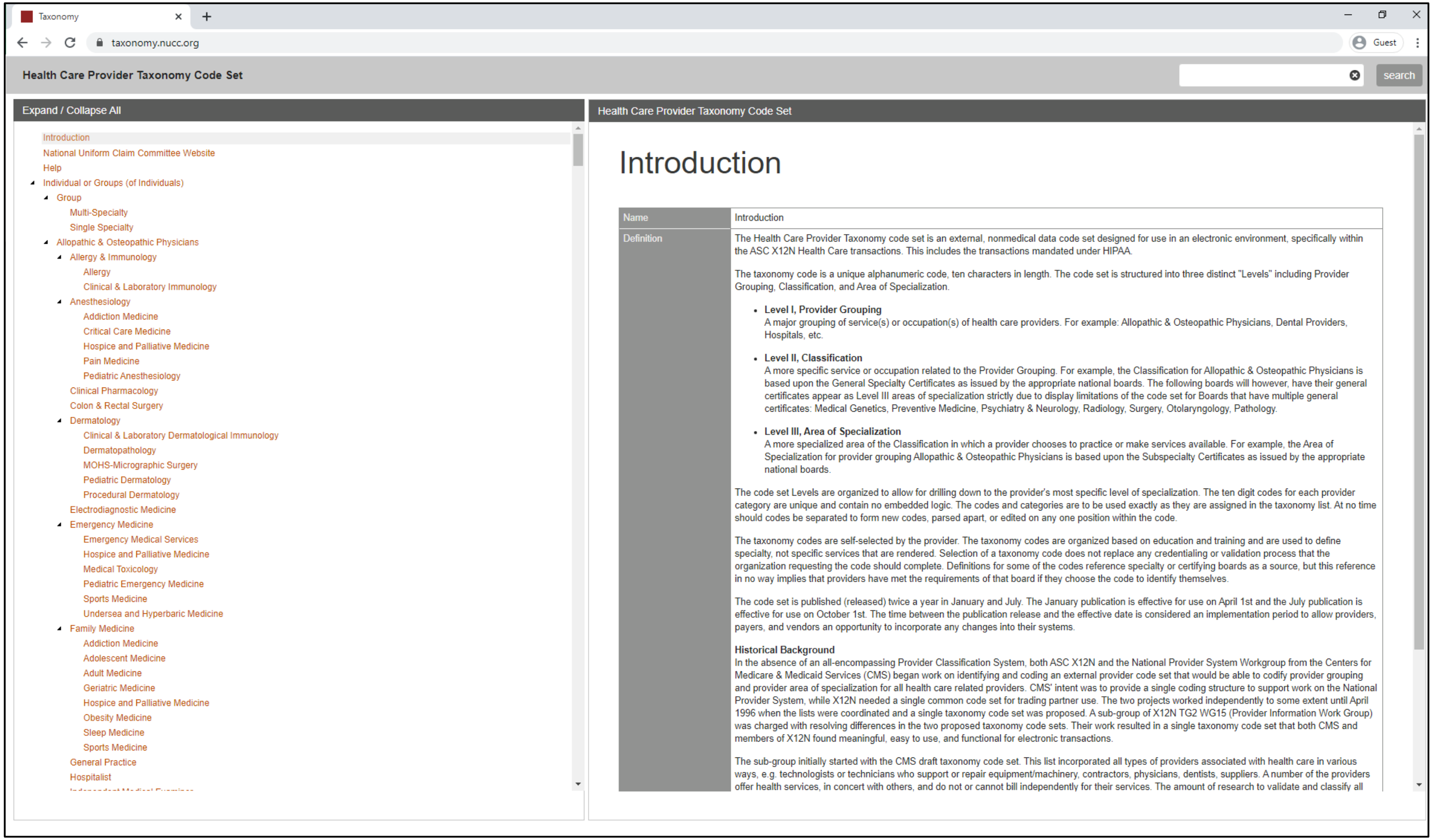
End Date:

Confirm Taxonomy
✓ Ok
Cancel

Page ID: dlgEnrlAddTaxonomy(Provider)

©2019 CNSI

NUCC Taxonomy Code List

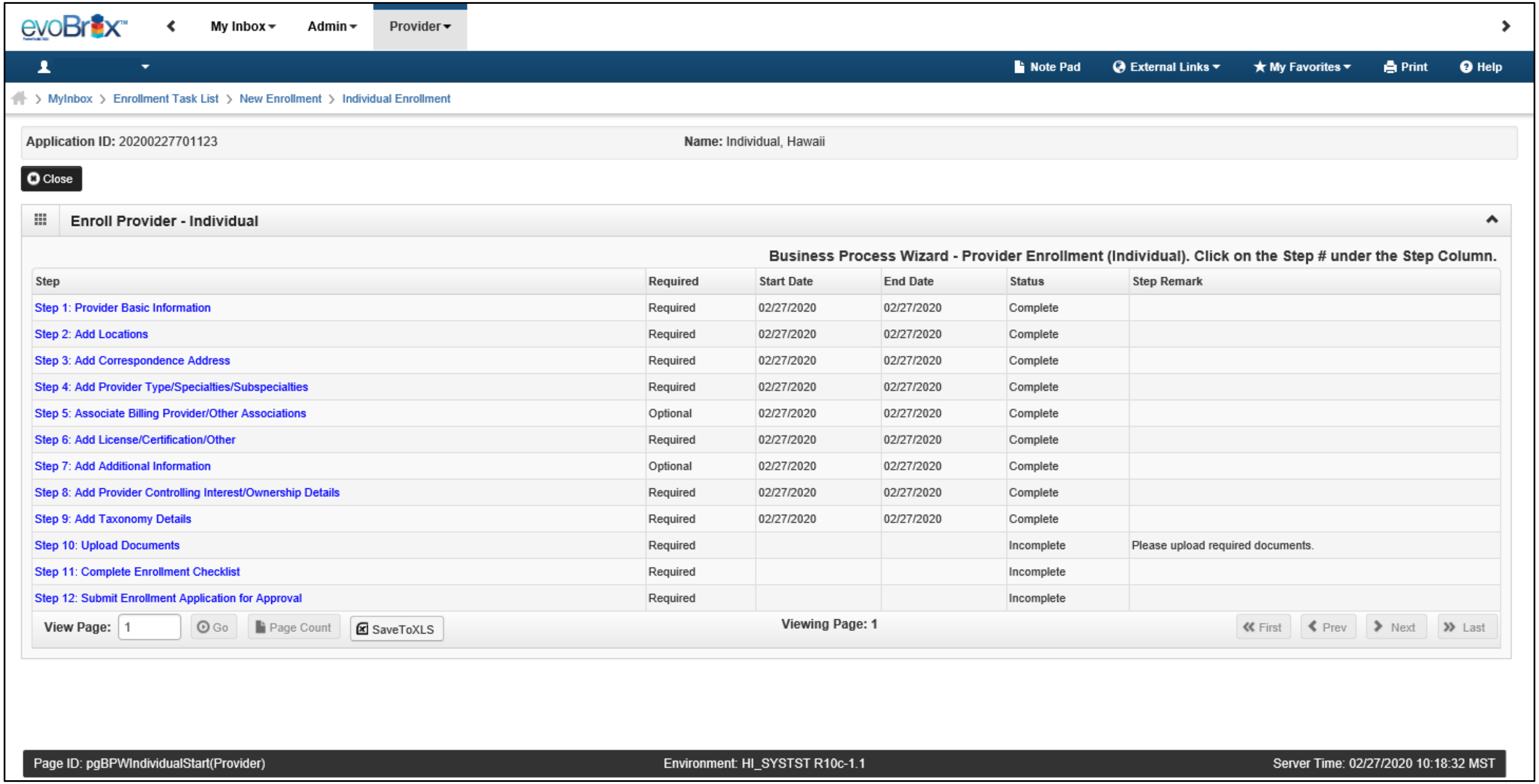

Taxonomy
taxonomy.nucc.org
Guest
Health Care Provider Taxonomy Code Set
search
Expand / Collapse All
Introduction
National Uniform Claim Committee Website
Help
Individual or Groups (of Individuals)
Group
Multi-Specialty
Single Specialty
Allopathic & Osteopathic Physicians
Allergy & Immunology
Allergy
Clinical & Laboratory Immunology
Anesthesiology
Addiction Medicine
Critical Care Medicine
Hospice and Palliative Medicine
Pain Medicine
Pediatric Anesthesiology
Clinical Pharmacology
Colon & Rectal Surgery
Dermatology
Clinical & Laboratory Dermatological Immunology
Dermatopathology
MOHS-Micrographic Surgery
Pediatric Dermatology
Procedural Dermatology
Electrodiagnostic Medicine
Emergency Medicine
Emergency Medical Services
Hospice and Palliative Medicine
Medical Toxicology
Pediatric Emergency Medicine
Sports Medicine
Undersea and Hyperbaric Medicine
Family Medicine
Addiction Medicine
Adolescent Medicine
Adult Medicine
Geriatric Medicine
Hospice and Palliative Medicine
Obesity Medicine
Sleep Medicine
Sports Medicine
General Practice
Hospitalist
Health Care Provider Taxonomy Code Set

Introduction

Name	Introduction
Definition	The Health Care Provider Taxonomy code set is an external, nonmedical data code set designed for use in an electronic environment, specifically within the ASC X12N Health Care transactions. This includes the transactions mandated under HIPAA. The taxonomy code is a unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Grouping, Classification, and Area of Specialization. • **Level I, Provider Grouping** A major grouping of service(s) or occupation(s) of health care providers. For example: Allopathic & Osteopathic Physicians, Dental Providers, Hospitals, etc. • **Level II, Classification** A more specific service or occupation related to the Provider Grouping. For example, the Classification for Allopathic & Osteopathic Physicians is based upon the General Specialty Certificates as issued by the appropriate national boards. The following boards will however, have their general certificates appear as Level III areas of specialization strictly due to display limitations of the code set for Boards that have multiple general certificates: Medical Genetics, Preventive Medicine, Psychiatry & Neurology, Radiology, Surgery, Otolaryngology, Pathology. • **Level III, Area of Specialization** A more specialized area of the Classification in which a provider chooses to practice or make services available. For example, the Area of Specialization for provider grouping Allopathic & Osteopathic Physicians is based upon the Subspecialty Certificates as issued by the appropriate national boards. The code set Levels are organized to allow for drilling down to the provider's most specific level of specialization. The ten digit codes for each provider category are unique and contain no embedded logic. The codes and categories are to be used exactly as they are assigned in the taxonomy list. At no time should codes be separated to form new codes, parsed apart, or edited on any one position within the code. The taxonomy codes are self-selected by the provider. The taxonomy codes are organized based on education and training and are used to define specialty, not specific services that are rendered. Selection of a taxonomy code does not replace any credentialing or validation process that the organization requesting the code should complete. Definitions for some of the codes reference specialty or certifying boards as a source, but this reference in no way implies that providers have met the requirements of that board if they choose the code to identify themselves. The code set is published (released) twice a year in January and July. The January publication is effective for use on April 1st and the July publication is effective for use on October 1st. The time between the publication release and the effective date is considered an implementation period to allow providers, payers, and vendors an opportunity to incorporate any changes into their systems. **Historical Background** In the absence of an all-encompassing Provider Classification System, both ASC X12N and the National Provider System Workgroup from the Centers for Medicare & Medicaid Services (CMS) began work on identifying and coding an external provider code set that would be able to codify provider grouping and provider area of specialization for all health care related providers. CMS' intent was to provide a single coding structure to support work on the National Provider System, while X12N needed a single common code set for trading partner use. The two projects worked independently to some extent until April 1996 when the lists were coordinated and a single taxonomy code set was proposed. A sub-group of X12N TG2 WG15 (Provider Information Work Group) was charged with resolving differences in the two proposed taxonomy code sets. Their work resulted in a single taxonomy code set that both CMS and members of X12N found meaningful, easy to use, and functional for electronic transactions. The sub-group initially started with the CMS draft taxonomy code set. This list incorporated all types of providers associated with health care in various ways, e.g. technologists or technicians who support or repair equipment/machinery, contractors, physicians, dentists, suppliers. A number of the providers offer health services, in concert with others, and do not or cannot bill independently for their services. The amount of research to validate and classify all

©2019 CNSI

Step 10: Upload Documents


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Enroll Provider - Individual
View Page:
Go
Page Count
SaveToXLS
First
Prev
Next
Last

Application ID: 20200227701123

Name: Individual, Hawaii

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/27/2020	02/27/2020	Complete	
Step 2: Add Locations	Required	02/27/2020	02/27/2020	Complete	
Step 3: Add Correspondence Address	Required	02/27/2020	02/27/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/27/2020	02/27/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/27/2020	02/27/2020	Complete	
Step 6: Add License/Certification/Other	Required	02/27/2020	02/27/2020	Complete	
Step 7: Add Additional Information	Optional	02/27/2020	02/27/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/27/2020	02/27/2020	Complete	
Step 9: Add Taxonomy Details	Required	02/27/2020	02/27/2020	Complete	
Step 10: Upload Documents	Required			Incomplete	Please upload required documents.
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

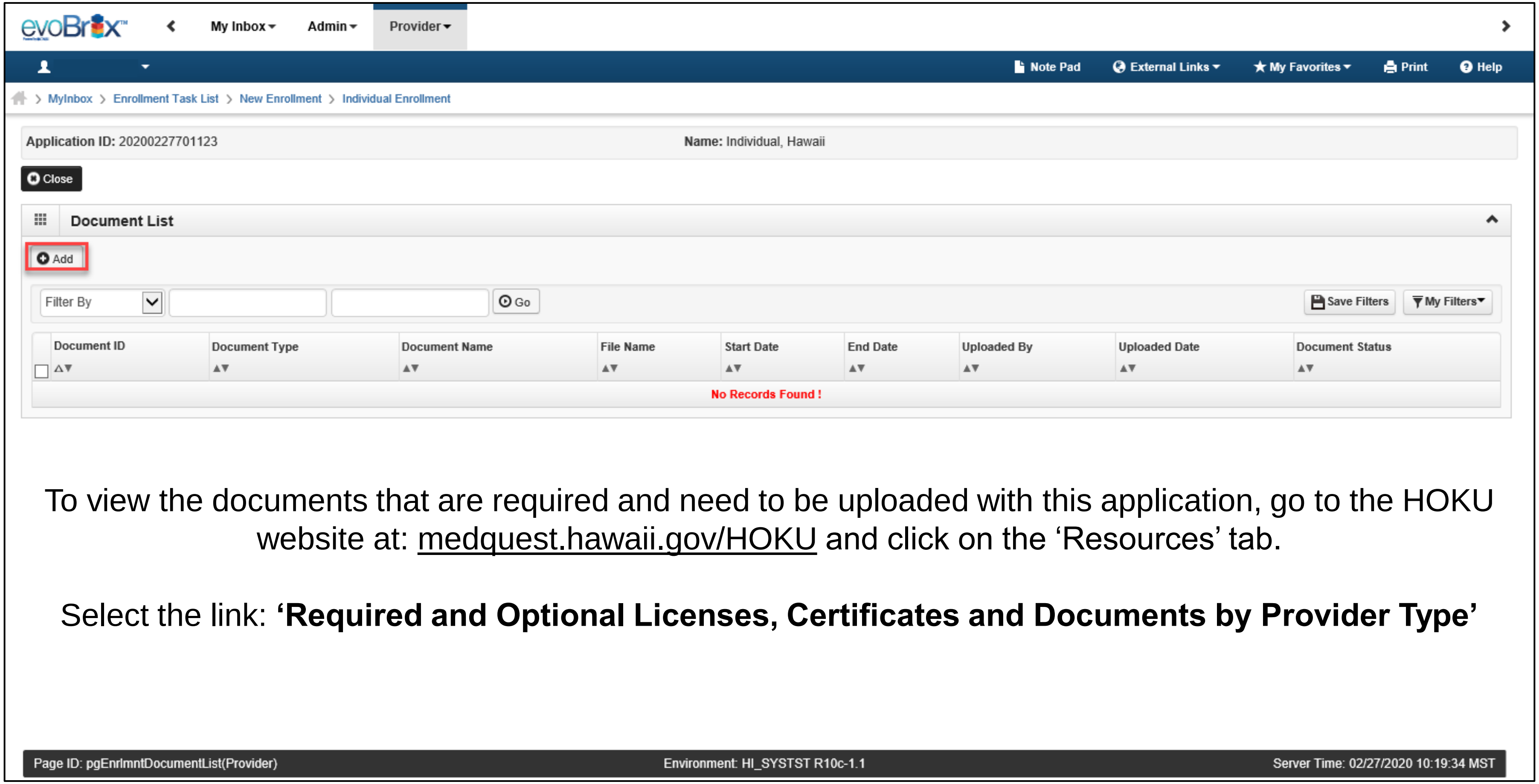
View Page: 1

Viewing Page: 1

Page ID: pgBPWIndividualStart(Provider)   Environment: HI_SYSTST R10c-1.1   Server Time: 02/27/2020 10:18:32 MST

©2019 CNSI

Upload Documents


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
Close
Document List
Add
Filter By
Go
Save Filters
My Filters

MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment

Application ID: 20200227701123 **Name:** Individual, Hawaii

☐	Document ID	Document Type	Document Name	File Name	Start Date	End Date	Uploaded By	Uploaded Date	Document Status
	No Records Found !								

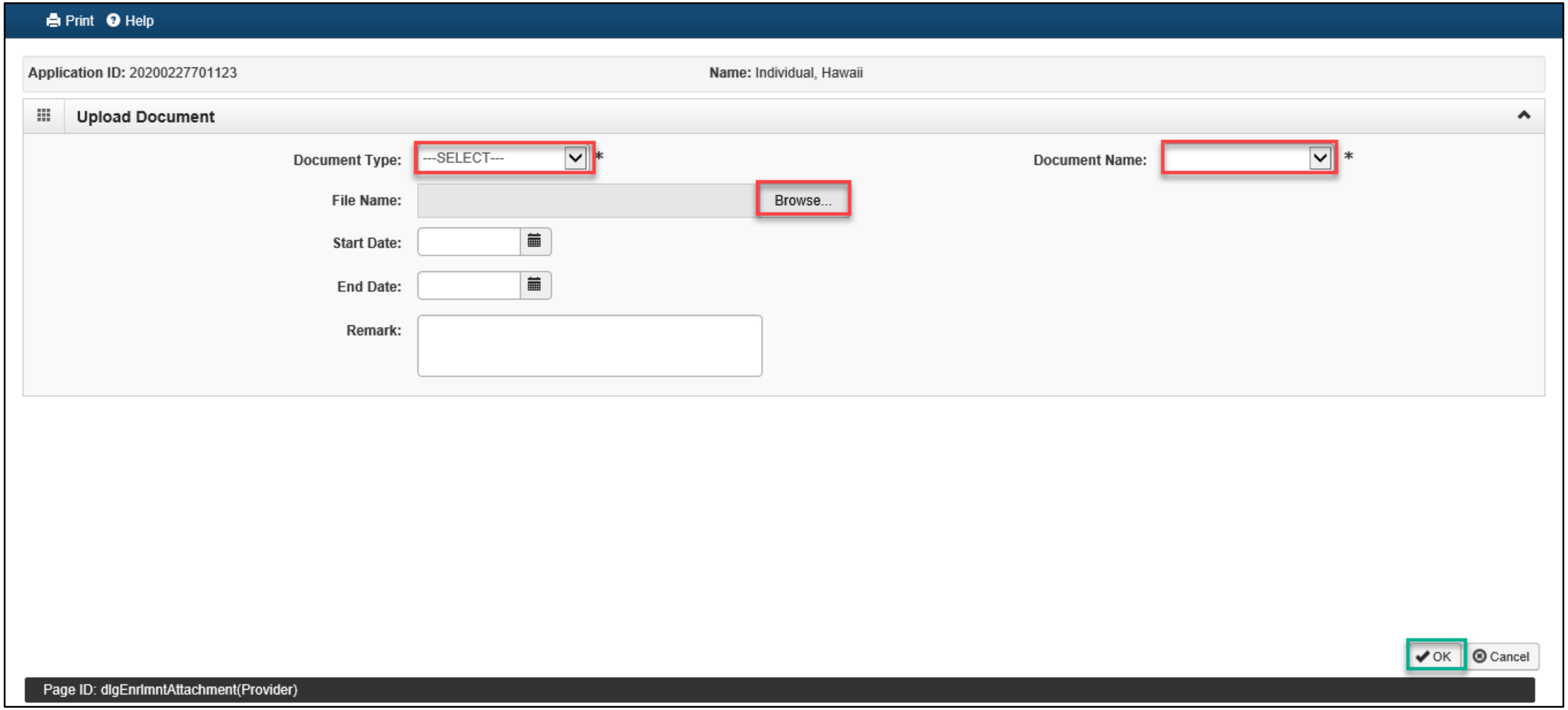
Page ID: pgEnrlmntDocumentList(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 10:19:34 MST

To view the documents that are required and need to be uploaded with this application, go to the HOKU website at: medquest.hawaii.gov/HOKU and click on the ‘Resources’ tab.

Select the link: **‘Required and Optional Licenses, Certificates and Documents by Provider Type’**

©2019 CNSI

Upload Documents



Print
Help

Application ID: 20200227701123

Name: Individual, Hawaii

Upload Document

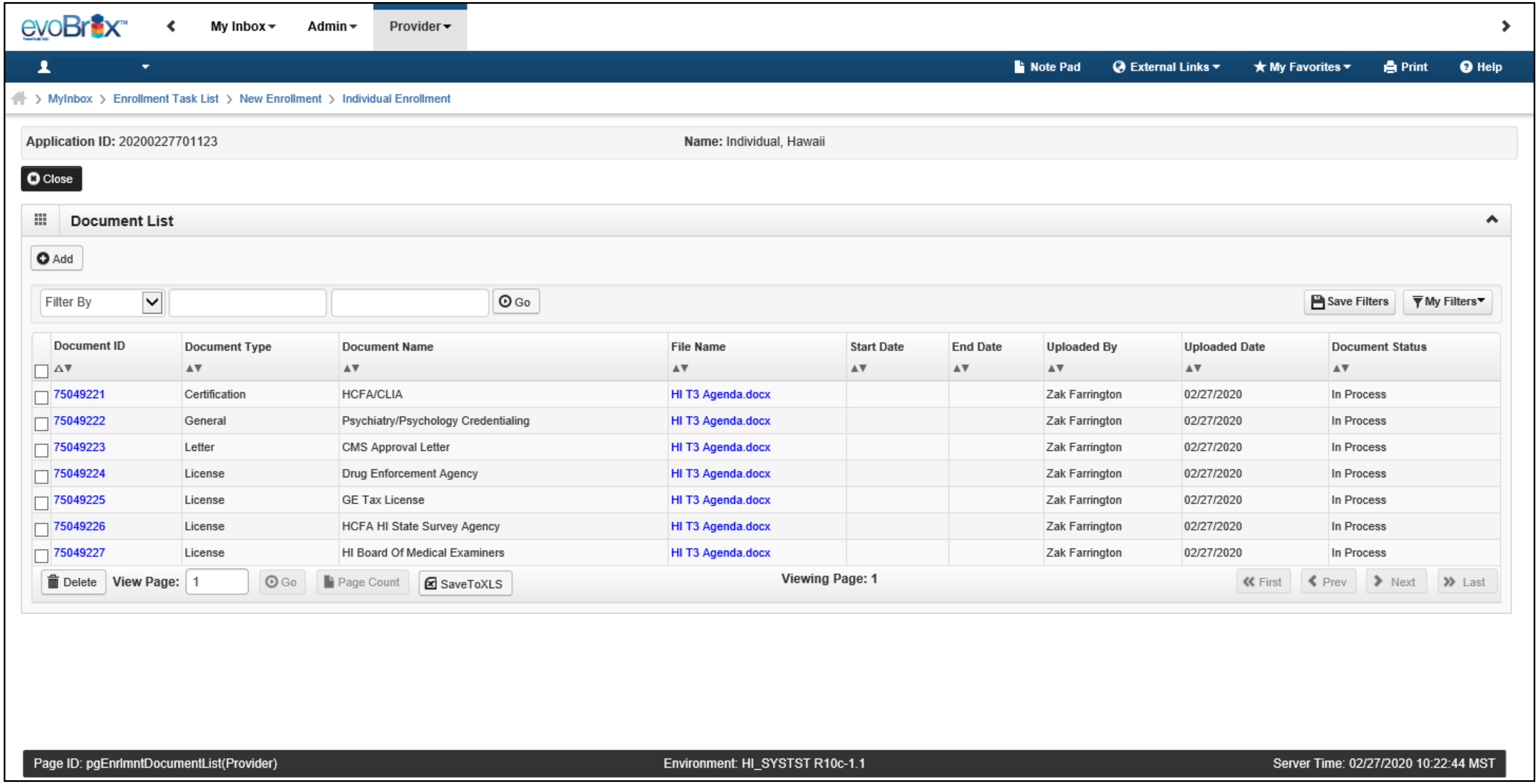
Document Type:	---SELECT--- *
Document Name:	*
File Name:	
Start Date:	
End Date:	
Remark:	

Browse...
OK
Cancel

Page ID: dlgEnrlmntAttachment(Provider)

©2019 CNSI

Upload Documents List


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
Close
Document List
Add
Filter By
Go
Save Filters
My Filters
Delete
Go
Page Count
SaveToXLS
First
Prev
Next
Last

MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment

Application ID: 20200227701123

Name: Individual, Hawaii

☐	Document ID	Document Type	Document Name	File Name	Start Date	End Date	Uploaded By	Uploaded Date	Document Status
☐	75049221	Certification	HCFA/CLIA	HI T3 Agenda.docx			Zak Farrington	02/27/2020	In Process
☐	75049222	General	Psychiatry/Psychology Credentialing	HI T3 Agenda.docx			Zak Farrington	02/27/2020	In Process
☐	75049223	Letter	CMS Approval Letter	HI T3 Agenda.docx			Zak Farrington	02/27/2020	In Process
☐	75049224	License	Drug Enforcement Agency	HI T3 Agenda.docx			Zak Farrington	02/27/2020	In Process
☐	75049225	License	GE Tax License	HI T3 Agenda.docx			Zak Farrington	02/27/2020	In Process
☐	75049226	License	HCFA HI State Survey Agency	HI T3 Agenda.docx			Zak Farrington	02/27/2020	In Process
☐	75049227	License	HI Board Of Medical Examiners	HI T3 Agenda.docx			Zak Farrington	02/27/2020	In Process

View Page: 1

Viewing Page: 1

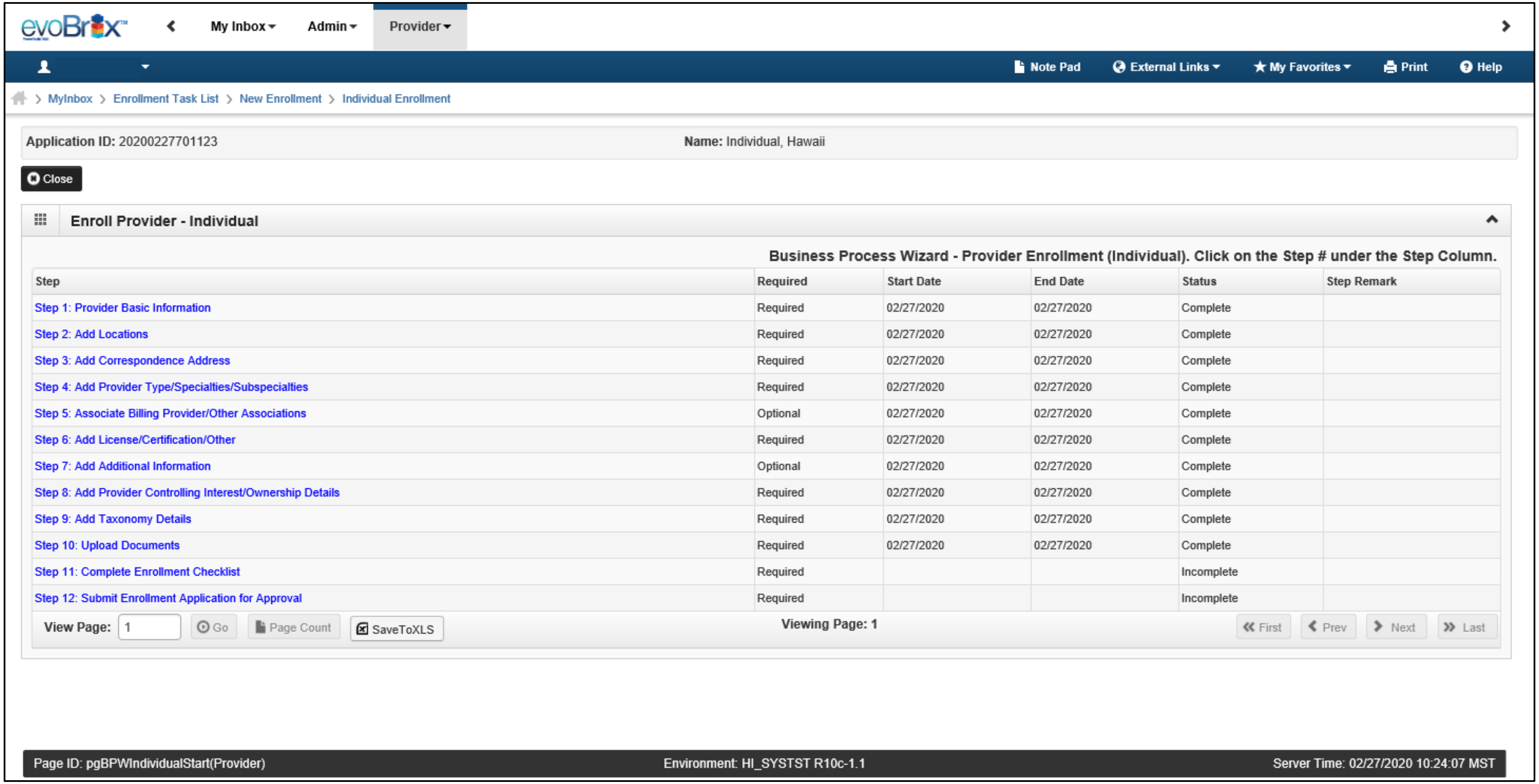
Page ID: pgEnrlmntDocumentList(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/27/2020 10:22:44 MST

©2019 CNSI

Step 11: Enrollment Checklist


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
SaveToXLS
Go
Page Count
First
Prev
Next
Last

Application ID: 20200227701123 **Name:** Individual, Hawaii

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/27/2020	02/27/2020	Complete	
Step 2: Add Locations	Required	02/27/2020	02/27/2020	Complete	
Step 3: Add Correspondence Address	Required	02/27/2020	02/27/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/27/2020	02/27/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/27/2020	02/27/2020	Complete	
Step 6: Add License/Certification/Other	Required	02/27/2020	02/27/2020	Complete	
Step 7: Add Additional Information	Optional	02/27/2020	02/27/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/27/2020	02/27/2020	Complete	
Step 9: Add Taxonomy Details	Required	02/27/2020	02/27/2020	Complete	
Step 10: Upload Documents	Required	02/27/2020	02/27/2020	Complete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

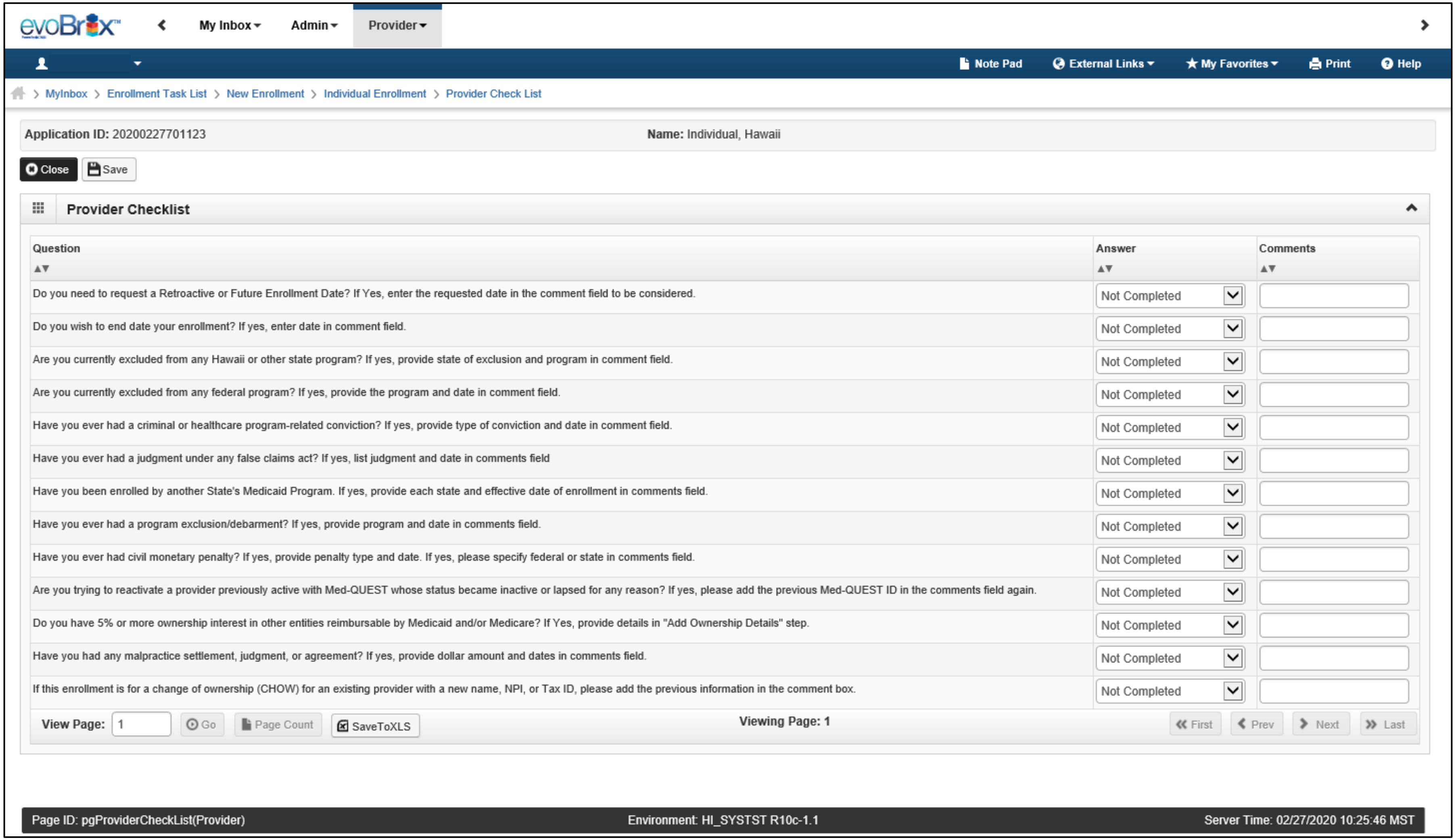
View Page: 1

Viewing Page: 1

Page ID: pgBPWIndividualStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 10:24:07 MST

©2019 CNSI

Enrollment Checklist



Application ID: 20200227701123

Name: Individual, Hawaii

Provider Checklist

Question	Answer	Comments
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	Not Completed	
Do you wish to end date your enrollment? If yes, enter date in comment field.	Not Completed	
Are you currently excluded from any Hawaii or other state program? If yes, provide state of exclusion and program in comment field.	Not Completed	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	Not Completed	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	Not Completed	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field	Not Completed	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	Not Completed	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	Not Completed	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	Not Completed	
Are you trying to reactivate a provider previously active with Med-QUEST whose status became inactive or lapsed for any reason? If yes, please add the previous Med-QUEST ID in the comments field again.	Not Completed	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	Not Completed	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	Not Completed	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	Not Completed	

View Page: 1

Viewing Page: 1

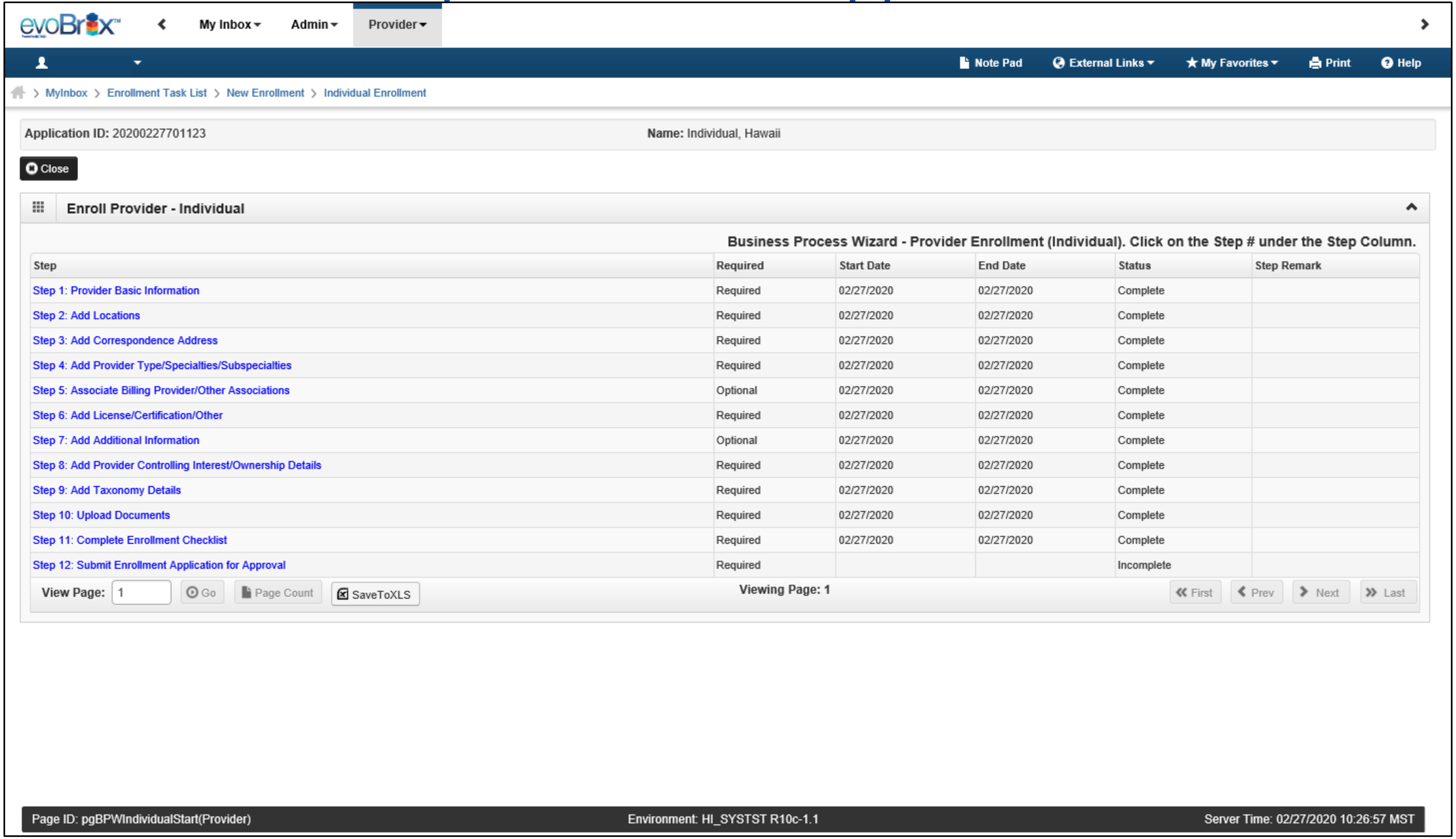
Page ID: pgProviderCheckList(Provider)

Environment: HI_SYSTST R10c-1.1

Server Time: 02/27/2020 10:25:46 MST

©2019 CNSI

Step 12: Submit Application


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Enroll Provider - Individual

Application ID: 20200227701123 **Name:** Individual, Hawaii

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

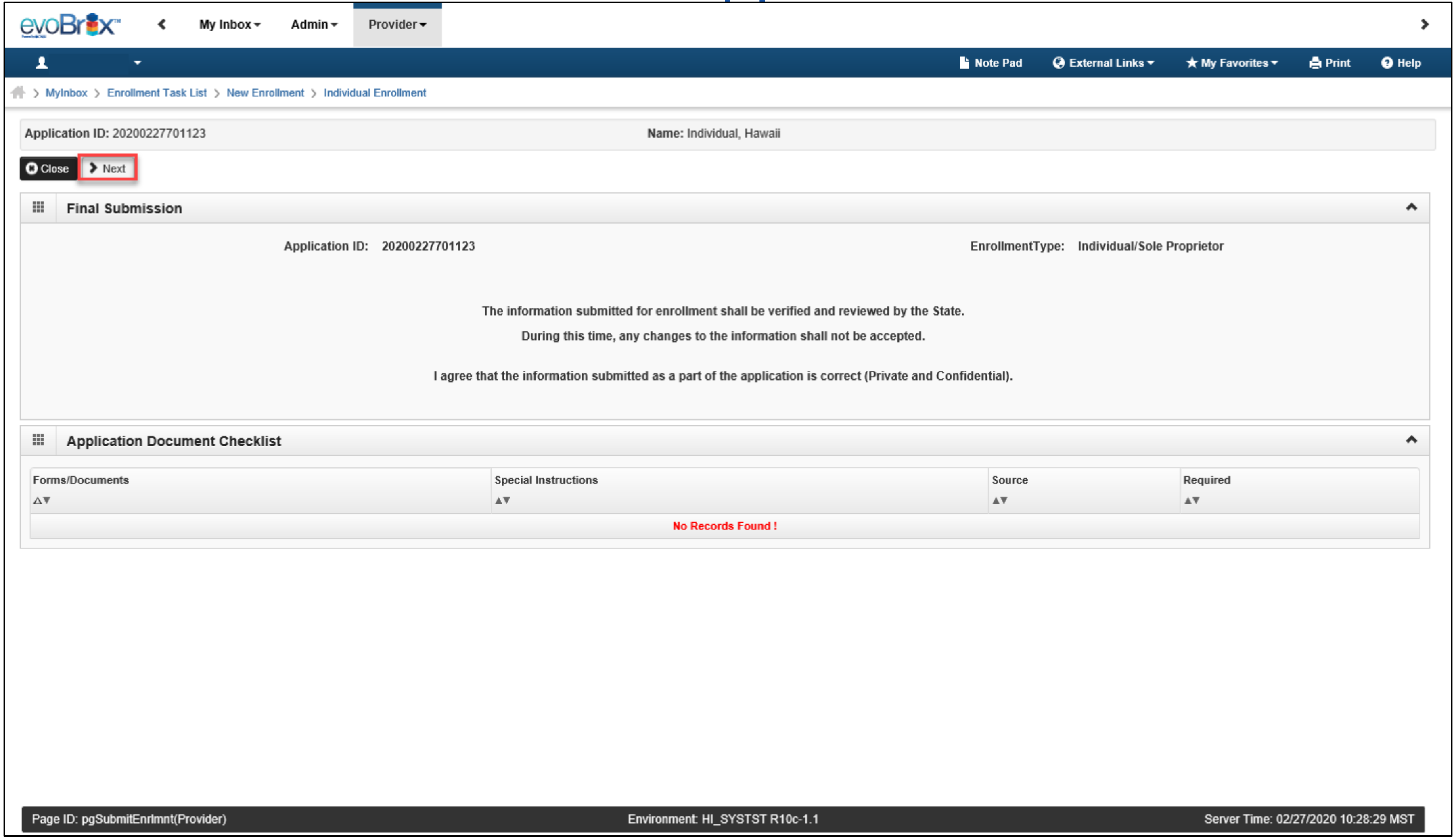
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/27/2020	02/27/2020	Complete	
Step 2: Add Locations	Required	02/27/2020	02/27/2020	Complete	
Step 3: Add Correspondence Address	Required	02/27/2020	02/27/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/27/2020	02/27/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/27/2020	02/27/2020	Complete	
Step 6: Add License/Certification/Other	Required	02/27/2020	02/27/2020	Complete	
Step 7: Add Additional Information	Optional	02/27/2020	02/27/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/27/2020	02/27/2020	Complete	
Step 9: Add Taxonomy Details	Required	02/27/2020	02/27/2020	Complete	
Step 10: Upload Documents	Required	02/27/2020	02/27/2020	Complete	
Step 11: Complete Enrollment Checklist	Required	02/27/2020	02/27/2020	Complete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1
Go
Page Count
SaveToXLS
Viewing Page: 1
First
Prev
Next
Last

Page ID: pgBPWIndividualStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 10:26:57 MST

©2019 CNSI

Submit Application


evoBrix
My Inbox
Admin
Provider
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
Next

Application ID: 20200227701123 **Name:** Individual, Hawaii

Final Submission

Application ID: 20200227701123

EnrollmentType: Individual/Sole Proprietor

The information submitted for enrollment shall be verified and reviewed by the State.

During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct (Private and Confidential).

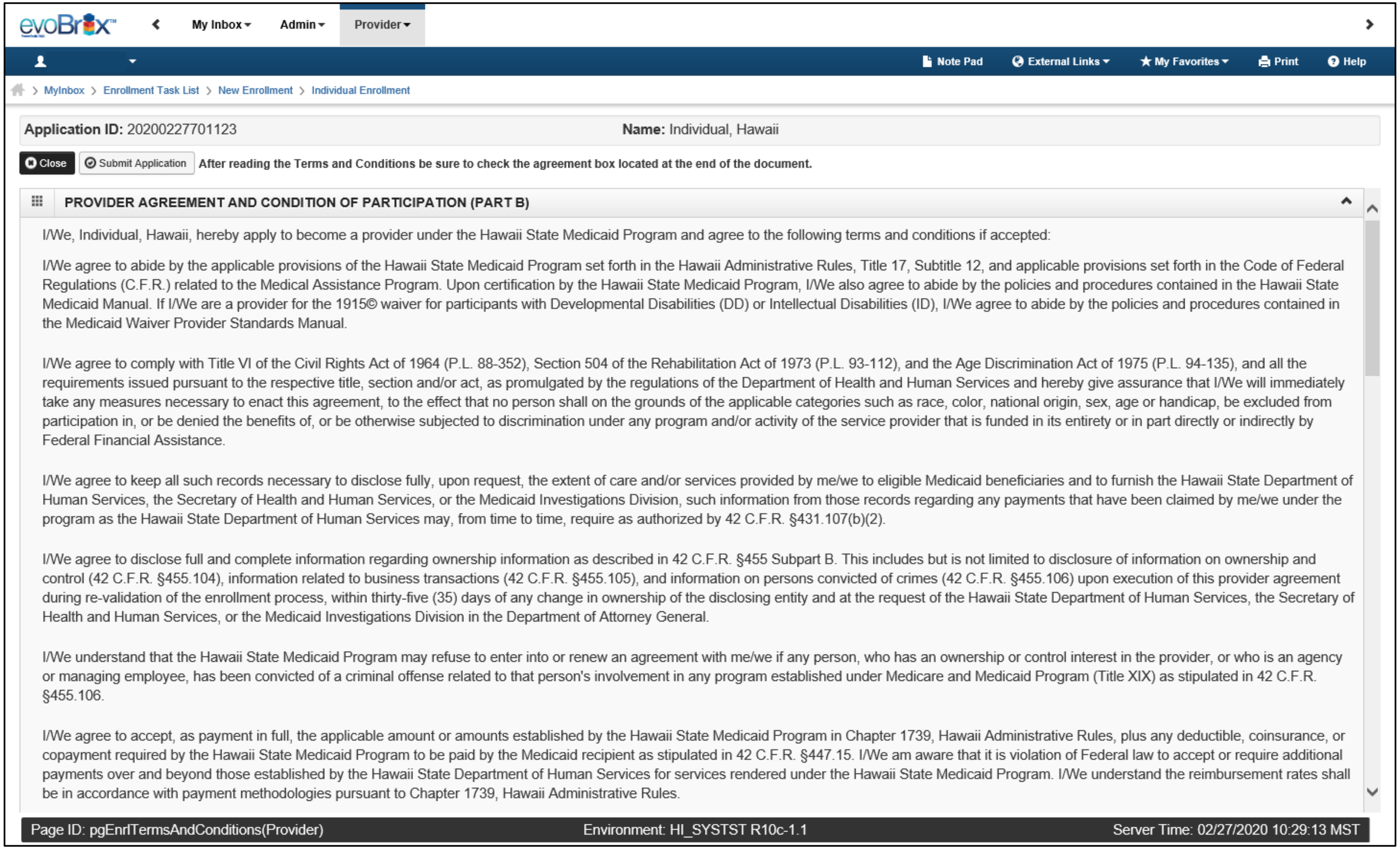
Application Document Checklist

Forms/Documents	Special Instructions	Source	Required
No Records Found !			

Page ID: pgSubmitEnrlmnt(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 10:28:29 MST

©2019 CNSI

Review Provider Participation Agreement



Application ID: 20200227701123 **Name:** Individual, Hawaii

After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.

PROVIDER AGREEMENT AND CONDITION OF PARTICIPATION (PART B)

I/We, Individual, Hawaii, hereby apply to become a provider under the Hawaii State Medicaid Program and agree to the following terms and conditions if accepted:

I/We agree to abide by the applicable provisions of the Hawaii State Medicaid Program set forth in the Hawaii Administrative Rules, Title 17, Subtitle 12, and applicable provisions set forth in the Code of Federal Regulations (C.F.R.) related to the Medical Assistance Program. Upon certification by the Hawaii State Medicaid Program, I/We also agree to abide by the policies and procedures contained in the Hawaii State Medicaid Manual. If I/We are a provider for the 1915© waiver for participants with Developmental Disabilities (DD) or Intellectual Disabilities (ID), I/We agree to abide by the policies and procedures contained in the Medicaid Waiver Provider Standards Manual.

I/We agree to comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352), Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), and the Age Discrimination Act of 1975 (P.L. 94-135), and all the requirements issued pursuant to the respective title, section and/or act, as promulgated by the regulations of the Department of Health and Human Services and hereby give assurance that I/We will immediately take any measures necessary to enact this agreement, to the effect that no person shall on the grounds of the applicable categories such as race, color, national origin, sex, age or handicap, be excluded from participation in, or be denied the benefits of, or be otherwise subjected to discrimination under any program and/or activity of the service provider that is funded in its entirety or in part directly or indirectly by Federal Financial Assistance.

I/We agree to keep all such records necessary to disclose fully, upon request, the extent of care and/or services provided by me/we to eligible Medicaid beneficiaries and to furnish the Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division, such information from those records regarding any payments that have been claimed by me/we under the program as the Hawaii State Department of Human Services may, from time to time, require as authorized by 42 C.F.R. §431.107(b)(2).

I/We agree to disclose full and complete information regarding ownership information as described in 42 C.F.R. §455 Subpart B. This includes but is not limited to disclosure of information on ownership and control (42 C.F.R. §455.104), information related to business transactions (42 C.F.R. §455.105), and information on persons convicted of crimes (42 C.F.R. §455.106) upon execution of this provider agreement during re-validation of the enrollment process, within thirty-five (35) days of any change in ownership of the disclosing entity and at the request of the Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division in the Department of Attorney General.

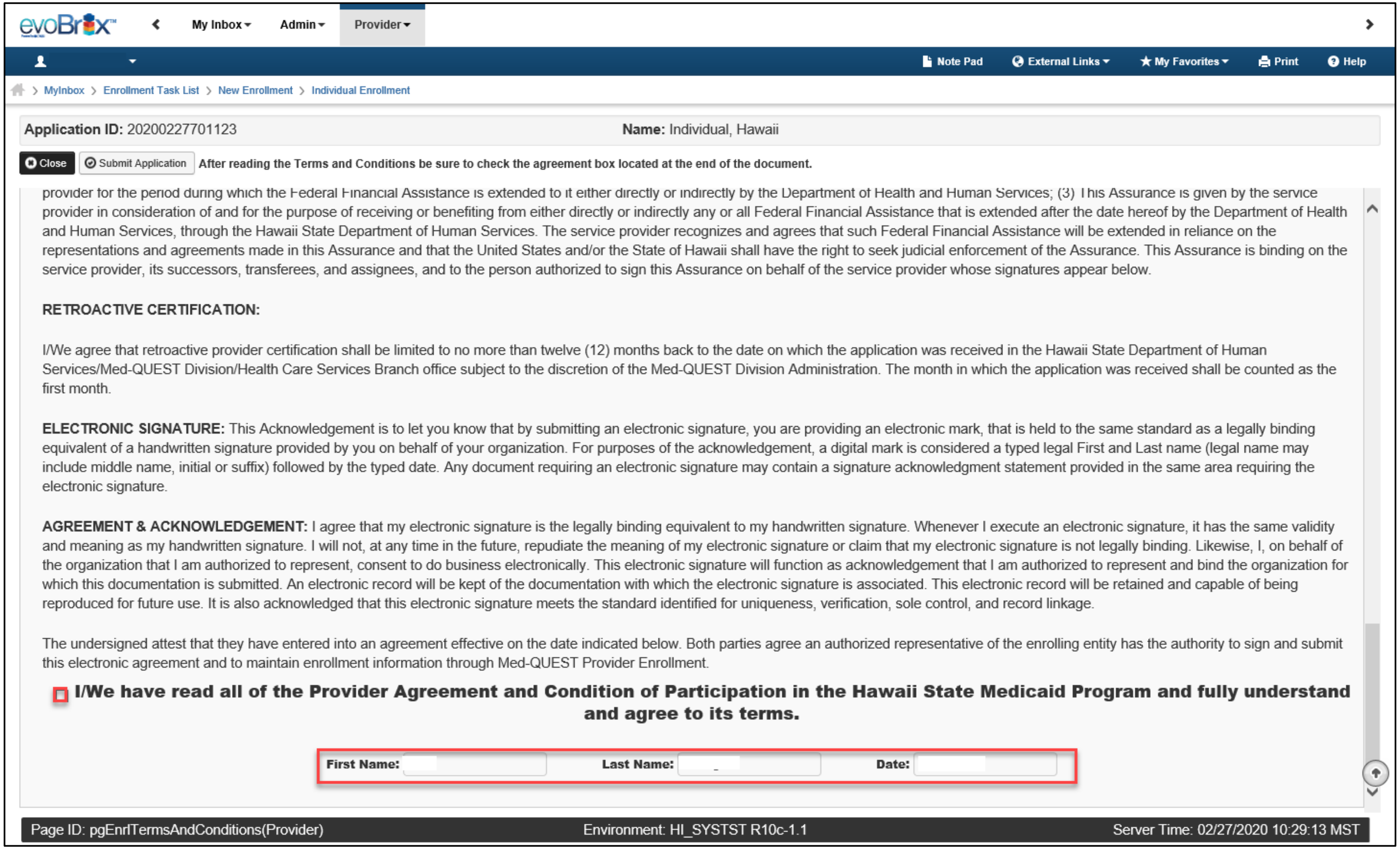
I/We understand that the Hawaii State Medicaid Program may refuse to enter into or renew an agreement with me/we if any person, who has an ownership or control interest in the provider, or who is an agency or managing employee, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare and Medicaid Program (Title XIX) as stipulated in 42 C.F.R. §455.106.

I/We agree to accept, as payment in full, the applicable amount or amounts established by the Hawaii State Medicaid Program in Chapter 1739, Hawaii Administrative Rules, plus any deductible, coinsurance, or copayment required by the Hawaii State Medicaid Program to be paid by the Medicaid recipient as stipulated in 42 C.F.R. §447.15. I/We am aware that it is violation of Federal law to accept or require additional payments over and beyond those established by the Hawaii State Department of Human Services for services rendered under the Hawaii State Medicaid Program. I/We understand the reimbursement rates shall be in accordance with payment methodologies pursuant to Chapter 1739, Hawaii Administrative Rules.

Page ID: pgEnrlTermsAndConditions(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 10:29:13 MST

©2019 CNSI

Review Provider Participation Agreement



Application ID: 20200227701123 **Name:** Individual, Hawaii

After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.

provider for the period during which the Federal Financial Assistance is extended to it either directly or indirectly by the Department of Health and Human Services; (3) This Assurance is given by the service provider in consideration of and for the purpose of receiving or benefiting from either directly or indirectly any or all Federal Financial Assistance that is extended after the date hereof by the Department of Health and Human Services, through the Hawaii State Department of Human Services. The service provider recognizes and agrees that such Federal Financial Assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States and/or the State of Hawaii shall have the right to seek judicial enforcement of the Assurance. This Assurance is binding on the service provider, its successors, transferees, and assignees, and to the person authorized to sign this Assurance on behalf of the service provider whose signatures appear below.

RETROACTIVE CERTIFICATION:

I/We agree that retroactive provider certification shall be limited to no more than twelve (12) months back to the date on which the application was received in the Hawaii State Department of Human Services/Med-QUEST Division/Health Care Services Branch office subject to the discretion of the Med-QUEST Division Administration. The month in which the application was received shall be counted as the first month.

ELECTRONIC SIGNATURE: This Acknowledgement is to let you know that by submitting an electronic signature, you are providing an electronic mark, that is held to the same standard as a legally binding equivalent of a handwritten signature provided by you on behalf of your organization. For purposes of the acknowledgement, a digital mark is considered a typed legal First and Last name (legal name may include middle name, initial or suffix) followed by the typed date. Any document requiring an electronic signature may contain a signature acknowledgment statement provided in the same area requiring the electronic signature.

AGREEMENT & ACKNOWLEDGEMENT: I agree that my electronic signature is the legally binding equivalent to my handwritten signature. Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding. Likewise, I, on behalf of the organization that I am authorized to represent, consent to do business electronically. This electronic signature will function as acknowledgement that I am authorized to represent and bind the organization for which this documentation is submitted. An electronic record will be kept of the documentation with which the electronic signature is associated. This electronic record will be retained and capable of being reproduced for future use. It is also acknowledged that this electronic signature meets the standard identified for uniqueness, verification, sole control, and record linkage.

The undersigned attest that they have entered into an agreement effective on the date indicated below. Both parties agree an authorized representative of the enrolling entity has the authority to sign and submit this electronic agreement and to maintain enrollment information through Med-QUEST Provider Enrollment.

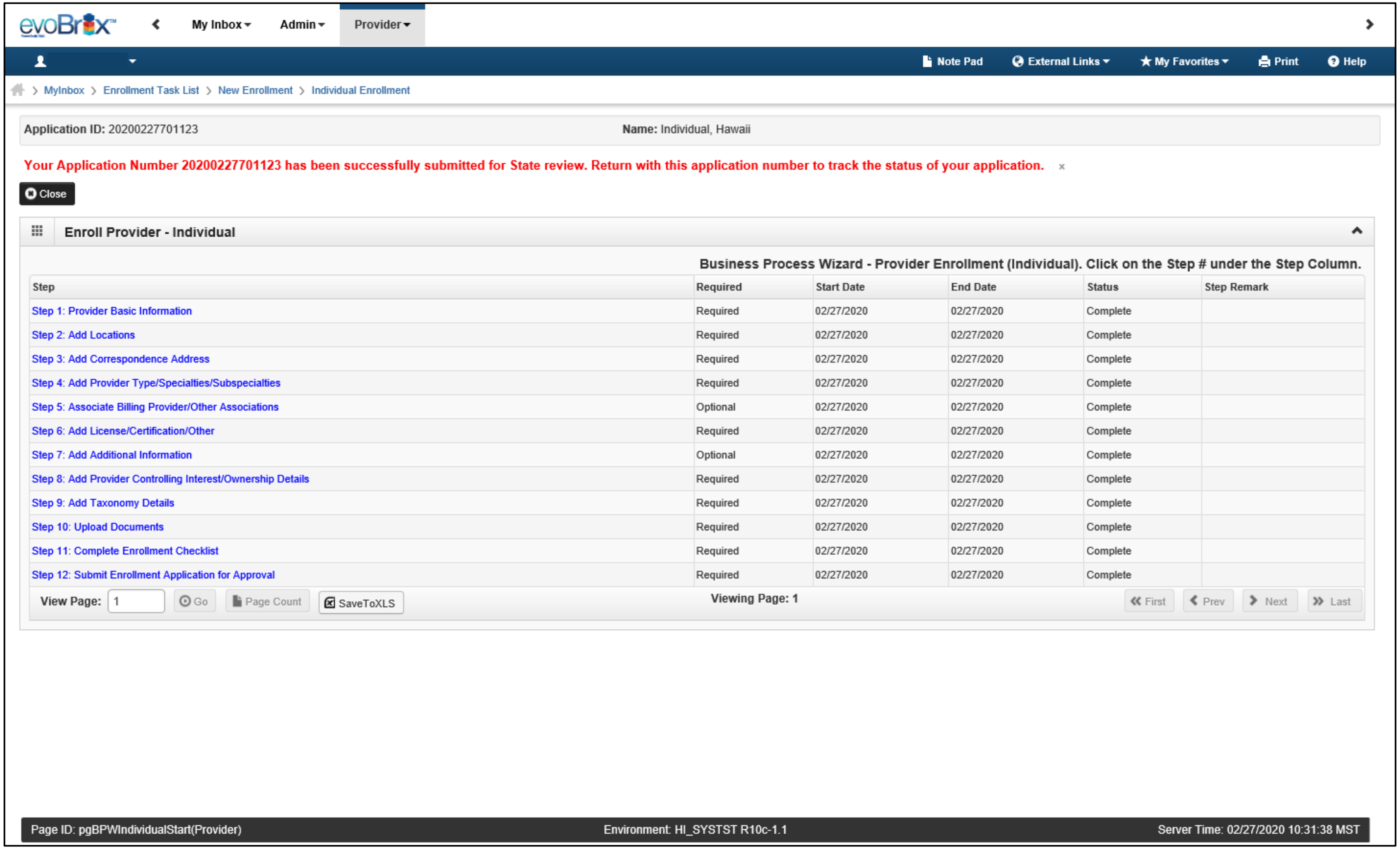
☐ **I/We have read all of the Provider Agreement and Condition of Participation in the Hawaii State Medicaid Program and fully understand and agree to its terms.**

First Name: **Last Name:** **Date:**

Page ID: pgEnrlTermsAndConditions(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 10:29:13 MST

©2019 CNSI

Submission Complete


evoBrix™
My Inbox
Admin
Provider
[redacted]
Note Pad
External Links
My Favorites
Print
Help
MyInbox > Enrollment Task List > New Enrollment > Individual Enrollment
Close
View Page:
Go
Page Count
SaveToXLS
First
Prev
Next
Last

Application ID: 20200227701123 **Name:** Individual, Hawaii

Your Application Number 20200227701123 has been successfully submitted for State review. Return with this application number to track the status of your application.

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/27/2020	02/27/2020	Complete	
Step 2: Add Locations	Required	02/27/2020	02/27/2020	Complete	
Step 3: Add Correspondence Address	Required	02/27/2020	02/27/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/27/2020	02/27/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/27/2020	02/27/2020	Complete	
Step 6: Add License/Certification/Other	Required	02/27/2020	02/27/2020	Complete	
Step 7: Add Additional Information	Optional	02/27/2020	02/27/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/27/2020	02/27/2020	Complete	
Step 9: Add Taxonomy Details	Required	02/27/2020	02/27/2020	Complete	
Step 10: Upload Documents	Required	02/27/2020	02/27/2020	Complete	
Step 11: Complete Enrollment Checklist	Required	02/27/2020	02/27/2020	Complete	
Step 12: Submit Enrollment Application for Approval	Required	02/27/2020	02/27/2020	Complete	

View Page: 1

Viewing Page: 1

Page ID: pgBPWIndividualStart(Provider) Environment: HI_SYSTST R10c-1.1 Server Time: 02/27/2020 10:31:38 MST

©2019 CNSI

Contact Med-QUEST

https://medquest.hawaii.gov/HOKU

Email: hcsbinquiries@dhs.hawaii.gov
Phone: 808-692-8099
Fax: 808-692-8087

Office Address:
601 Kamokila Boulevard, Room 506A
Kapolei, HI 96707

Thank You!

Persistence, Perseverance and Passion as always remains our credo.