STATE OF HAWAII
**DEPARTMENT OF HUMAN SERVICES**
Med-QUEST Division
Health Care Services Branch
601 Kamokila Boulevard, Room 506A
Kapolei, Hawaii 96707

Dear Applicant:

The Affordable Care Act (ACA) required changes to the Med-QUEST Division's (MQD) processing of provider applications for the fee-for-service (FFS) program. A list of these requirements is provided below.

**The MQD is required to obtain a $500 application fee from all providers EXCEPT for non-institutional providers. A partial list of non-institutional providers include Physicians, Psychiatrists, Podiatrists, Optometrists, APRNs, Physician Assistants, RNs, Dentists, among others. Institutional providers must submit a money order or cashiers check for $500 when submitting your application, payable to:**

**State Director of Finance**
**c/o Med-QUEST Division**
**Health Care Services Branch, Provider Enrollment**
**601 Kamokila Boulevard, Room 506A**
**Kapolei, Hawaii 96707**

MANAGED CARE

Managed care health plans will continue to perform credentialing of providers. Below is a list of contacts for managed care health plans that participate in the Medicaid program. Please note that the majority of Medicaid beneficiaries are provided services through managed care; FFS only supports approximately 100 to 200 beneficiaries monthly.

| *Health Plan* | *Contact Information* |
|---|---|
| AlohaCare | Provider Relations at 973-1650 or toll-free at 1-800-434-1002<br>www.alohacare.org |
| HMSA | Provider Services at 948-6486 or toll-free at 1-800-440-0640<br>www.hmsa.com |
| 'Ohana Health | 1-888-846-4262 or www.ohanahealthplan.com |
| UnitedHealthcare Community Plan | 1-888-980-8728 or www.uhccommunityplan.com |

For more information, click here

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Care Services Branch
601 Kamokila Blvd., Rm 506A
Kapolei, Hawaii 96707

# *MEDICAID APPLICATION / CHANGE REQUEST FORM*

**(PART A)**

☐ Group
☐ Individual

***Provider is currently credentialed with (attach credentialing documents with proof of $500 payment):***

| | |
|---|---|
| ***CHIP FROM ANOTHER STATE: State Abbreviation_____ ( Y / N )*** <br> ***MEDICARE: ( Y / N )*** | ***MEDICAID FROM ANOTHER STATE: State Abbreviation_____( Y / N )*** |

***Medicaid Application type:***

| | | |
|---|---|---|
| ***1) NEW ( Y / N )*** | ***2.) 5 –YEAR RE-VALIDATION ( Y / N )*** | ***3) CHANGE REQUEST ( Y / N )*** |

*If application type #1 or #2, check box to confirm enclosed $500 money order* ☐

***SHADED FIELDS FOR MED-QUEST PROVIDER REGISTRATION STAFF ONLY*** ***Please Type or Print in Ink***

**SECTION I**

1) NATIONAL PROVIDER IDENTIFIER NUMBER
*(Enter your 10-digit number, if applicable)*
__ __ __ __ __ __ __ __ __ __

2) PROVIDER NAME *(Last Name/First Name/Middle Initial)*

3) PROVIDER'S REGISTERED BUSINESS NAME / DOING BUSINESS AS (d.b.a.) NAME
☐ SOLE PROPRIETORSHIP
☐ CORPORATION
☐ OTHER _____

4) SOCIAL SECURITY NUMBER
- -

5) SPECIALTY / DEGREE *(Attach Board Certificate or Letter)*

**DHS USE ONLY**
PROVIDER MEDICAID ID NUMBER:
_____

6) GENDER

7) DATE OF BIRTH
Month____Day____Year ____

8) FIRST DATE OF SERVICE FOR WHICH A CLAIM WILL BE SUBMITTED
Month_____Day____Year _____

**SECTION II ADDRESS INFORMATION**

☐ INITIAL SERVICE ADDRESS *(IF NEW APPLICANT)*
☐ ADDITIONAL SERVICE LOCATION ☐ CLOSE EXISTING LOCATION ☐ CHANGE EXISTING INFORMATION

**CORRESPONDENCE ADDRESS (C)**

9) ATTENTION TO:
10) STREET LINE 1:
11) STREET LINE 2:
12) CITY/STATE/ZIP:
13) BUSINESS PHONE: ( ) – 14) FAX NUMBER: ( ) –
15) E-MAIL ADDRESS:

**SERVICE ADDRESS (S)** **DHS USE ONLY** ____

16) ATTENTION TO:
17) STREET LINE 1:
18) STREET LINE 2:
19) CITY/STATE/ZIP:
20) BUSINESS PHONE: ( ) – 21) FAX NUMBER: ( ) –
22) BEGIN DATE: / / 23) END DATE: / /
24) CLIA NUMBER: *If Applicable* 25) NABP/NCPDP NO.: *If Applicable*

DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐YES ☐NO

**PAY TO ADDRESS (P)** **DHS USE ONLY** ____

26) ATTENTION TO:
27) STREET LINE 1:
28) STREET LINE 2:
29) CITY/STATE/ZIP:
30) BUSINESS PHONE: ( ) – 31) FAX NUMBER: ( ) –
32) BEGIN DATE: / / 33) END DATE: / /
34) FEDERAL TAX ID NUMBER: 35) GENERAL EXCISE TAX NUMBER:

DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐YES ☐NO

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Care Services Branch
601 Kamokila Blvd. Rm 506A
Kapolei, HI 96707

☐ ADDITIONAL SERVICE LOCATION ☐ CLOSE EXISTING LOCATION ☐ CHANGE EXISTING INFORMATION

| **SERVICE ADDRESS (S)** | **DHS USE ONLY** |
|---|---|
| 16) ATTENTION TO: | |
| 17) STREET LINE 1: | |
| 18) STREET LINE 2: | |
| 19) CITY/STATE/ZIP: | ____ |
| 20) BUSINESS PHONE: ( ) – 21) FAX NUMBER: ( ) – | |
| 22) BEGIN DATE: / / 23) END DATE: / / | |
| 24) CLIA NUMBER: *If Applicable* 25) NABP/NCPDP NO.: *If Applicable* | |
| DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO | |

| **PAY TO ADDRESS (P)** | DHS USE **ONLY** |
|---|---|
| 26) ATTENTION TO: | |
| 27) STREET LINE 1: | |
| 28) STREET LINE 2: | |
| 29) CITY/STATE/ZIP: | ____ |
| 30) BUSINESS PHONE: ( ) – 31) FAX NUMBER: ( ) – | |
| 32) BEGIN DATE: / / 33) END DATE: / / | |
| 34) FEDERAL TAX ID NUMBER: 35) GENERAL EXCISE TAX NUMBER: | |
| DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO | |

☐ ADDITIONAL SERVICE LOCATION ☐ CLOSE EXISTING LOCATION ☐ CHANGE EXISTING INFORMATION

| **SERVICE ADDRESS (S)** | **DHS USE ONLY** |
|---|---|
| 16) ATTENTION TO: | |
| 17) STREET LINE 1: | |
| 18) STREET LINE 2: | |
| 19) CITY/STATE/ZIP: | ____ |
| 20) BUSINESS PHONE: ( ) – 21) FAX NUMBER: ( ) – | |
| 22) BEGIN DATE: / / 23) END DATE: / / | |
| 24) CLIA NUMBER: 25) NABP/NCPDP NO.: | |
| DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO | |

| **PAY TO ADDRESS (P)** | **DHS USE ONLY** |
|---|---|
| 26) ATTENTION TO: | |
| 27) STREET LINE 1: | |
| 28) STREET LINE 2: | |
| 29) CITY/STATE/ZIP: | ____ |
| 30) BUSINESS PHONE: ( ) – 31) FAX NUMBER: ( ) – | |
| 32) BEGIN DATE: / / 33) END DATE: / / | |
| 34) FEDERAL TAX ID NUMBER: 35) GENERAL EXCISE TAX NUMBER: | |
| DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO | |

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**SECTION III ADDITIONAL INFORMATION**

**LICENSING AND CERTIFICATION**

| 36) LICENSE / CERTIFICATE NUMBER | 37) LICENSING / CERTIFYING AGENCY | 38) ISSUE DATE (MM/DD/YYYY) | 39) EXPIRATION DATE (MM/DD/YYYY) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

* A **COPY** OF THE LICENSE AND/OR CERTIFICATION **MUST BE ATTACHED**

**AUTHORIZED AGENTS**

| 40) AGENT SIGNATURE | 41) PRINT NAME | 42) BEGIN DATE (MM/DD/YYYY) | 43) END DATE (MM/DD/YYYY) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

NOTE: THAT ALL SIGNATURES MUST BE ORIGINAL. ATTACHED A SEPARATE SHEET IF NEEDED.

**GROUP BILLING AUTHORIZATION**

| 44) GROUP NAME | 45) ASSOCIATION BEGIN DATE (MM/DD/YYYY) | 46) ASSOCIATION END DATE (MM/DD/YYYY) |
|---|---|---|
| | | |
| | | |
| | | |

**MEDICARE INFORMATION** *(Mandatory for all providers. If not a Medicare provider indicate by placing N/A in block #46)*

| 47) MEDICARE ID NUMBER | |
|---|---|
| | |
| | |
| | |

***I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.***

48) PROVIDER SIGNATURE *(ONLY)*

49) DATE

50) PROVIDER NAME *(PLEASE TYPE OR PRINT)*

STATE OF HAWAII
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601 Kamokila Blvd., Rm 506A
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## FOR DHS USE ONLY - DETERMINATION

**APPROVAL / DENIAL:**

FEE-FOR-SERVICE Provider QMB ONLY Provider *(Medicare Co-Payment / Deductible ONLY)*

NEGOTIATED Provider *(Rates and/or Procedure Codes Attached)*

APPROVED_____ DENIED_____ *REASON FOR DENIAL NOTATED BELOW*

MM DD YY MM DD YY

**REASON:** _____

_____ _____

MQD AUTHORIZED SIGNATURE DATE

## FOR DHS USE ONLY - VALIDATION

| PROVIDER TYPE: | | ENROLLMENT BEGIN DATE: | | | | DATE COS ENTERED: *Per Attached* | | | |
|---|---|---|---|---|---|---|---|---|---|
| | CODE | | MM | DD | YY | | MM | DD | YY |

_____ _____

MQD AUTHORIZED SIGNATURE DATE

STATE OF HAWAII
Department Of Human Services

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601 Kamokila Blvd., Rm 506A
Kapolei, HI 96707

***PART B AND PART C***

*Read through the Provider Agreement and Condition of Participation.*

**HAWAII STATE MEDICAID PROGRAM**
**PROVIDER AGREEMENT AND CONDITION OF PARTICIPATION (PART B)**

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

1. 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.

2. 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.

3. 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).

4. 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.

5. 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.

6. 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.

7. I/We understand that when changes in Hawaii State Department of Human Services and Hawaii State Medicaid Program policies and procedures become necessary due to changes in State or Federal laws or regulations, that such change will take effect within thirty (30) days of receipt of written notice from the Hawaii State Department of Human Services or the Hawaii State Medicaid Program to me/we.

8. I/We understand that (1) Any information provided by the Hawaii State Department of Human Services and the Hawaii State Medicaid Program to a provider and by a provider to the Department or Medicaid Program, shall be treated confidentially and shall not be released to other agencies or persons without the written consent of the recipient except in accordance with Subtitle 12, Chapter 17-1702 of the Hawaii Administrative Rules; (2) Any information about Medicaid Providers and recipients shall be confidential and shall not be disclosed except in accordance with Subtitle 12, Chapter 1702-5 of the Hawaii Administrative Rules. Such confidential information includes, but is not limited to the names and addresses of individuals, social and economic circumstances of an individual, evaluations, and medical, psychological or psychiatric information about the individual; (3) The records of any person, including all communications or specific medical or epidemiological information contained therein, that indicates that a person has or has been tested for HIV/AIDS shall be strictly confidential and shall only be released in accordance with Chapter 325-101, Hawaii Revised Statutes; (4) Information regarding an individual's records and reports with respect to mental health and substance abuse services are confidential and may only be disclosed in accordance with Chapter 334-5, Hawaii Revised Statutes; (5) Any information pertaining to the provision of services related to pregnancy, family planning or venereal disease shall be treated as confidential and may be released in accordance with Chapter 577A-3, Hawaii Revised Statutes.

9. I/We shall comply with the provisions of the Federal Drug Free Act of 1988 (P.L. 100-690), Title V Subtitle D, which requires that the provider maintain a drug-free workplace.

10. I/We shall comply with the provisions of HIPAA. In this Agreement "HIPAA" means the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, Pub L. No. 104-191. PROVIDER is a "health care provider" under HIPAA. A "covered entity" is a health care provider that transmits information in a standard electronic transaction under 45 C.F.R. Parts 160 and 162. If PROVIDER is or becomes a "covered entity", then PROVIDER must comply with all of the rules adopted to implement HIPAA, including rules for privacy of individually identifiable information, security of electronic protected health information, transactions, and code sets, and national employer and provider identifiers. Refer to 45 C.F.R. Parts 160, 162 and 164.

11. I/We agree to have criminal history record check(s) conducted on myself/my employees consistent with State and Federal law and DHS Standards.

## (PART C)

I/We understand that I/We may be suspended or terminated from participation in the Hawaii State Medicaid Program for non-adherence to any of the preceding program requirements and for violation of any of the provisions of H.A.R. Subtitle 12, Chapter 17-1704 (Provider Fraud) and Chapter 17-1736 (Provider Provisions) which includes but is not limited to the following:

(1) Any provider's practice which is deemed harmful to public health, safety and welfare of Medicaid beneficiaries; (2) Not providing full and accurate disclosure of the identify of any person or persons who has been convicted of a criminal offense relating to Medicaid or Medicare; (3) Fraud against the Hawaii State Medicaid Program including, but not limited to, the claiming and receipt of payment or payments for services not rendered, submission of a duplicate claim to the Medicaid program with intent to defraud and acceptance of payments for services already paid, or deliberate preparation of a claim in a manner which causes higher payment than the amount entitled to; (4) Requiring and/or accepting any payment from a Medicaid beneficiary for services paid for by the Hawaii State Medicaid Program, except in cases where the Hawaii State Department of Human Services has identified a cost share to be paid by the beneficiary and where the beneficiary remits an amount equal to his or her cost share; (5) Requiring and receiving payment from a beneficiary to make up for the difference between the Hawaii State Department of Human Services' applicable fee schedule or rate and the provider's charges; (6) Revocation of the provider's license by the Hawaii State Department of Commerce and Consumer Affairs; (7) Withdrawal, expiration or termination of facility certification by the Hawaii State Department of Health; (8) Action taken by the provider's professional group or organization disapproving the provider's methods of treatment or care or a determination that care/services rendered by the provider are not in accordance with accepted practices of the profession or harmful to a beneficiary's health and safety; (9) Violation of the non-discrimination provisions; and (10) Notification from the Secretary of Health and Human Services, or person designated by him/her that an individual, hospital or nursing facility has withdrawn from participation in Medicare without refunding money it owes to Medicare or when the provider agreement has been terminated for defrauding Medicare.

**IN THE CASE OF PROVIDERS WHO ARE INDIVIDUALS**:

I agree that all services for which I make a claim against the Hawaii State Medicaid Program (Title XIX) will be personally rendered by me. Services such as administration of injections, immunizations, minimal dressings, and drawing of blood samples may be rendered by qualified support nursing staff.

**IN THE CASE OF PROVIDERS WHICH ARE BUSINESSES, GROUPS, HOSPITALS, CORPORATIONS OR OTHER ENTITIES**:

(1) I/We and each of us agree that all services for which our organization makes a claim against the Hawaii State Medicaid Program (Title XIX) shall be only for services rendered by persons who are properly licensed and/or qualified for the service they provide for which the claims are submitted; (2) If any real property or structure thereon is provided or improved either directly or indirectly by Federal

Financial Assistance from the Department of Health and Human Services, this Assurance shall obligate the service provider, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal Financial Assistance is extended or for another purpose involving the provision of similar services and/or benefits. If any personal property is so provided, this Assurance shall obligate the service provider for the period during which it retains ownership or possession of the property. In all other cases this Assurance shall obligate the service 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.

**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.**

_____
Print Name of Provider / Authorized Business Agent

_____
Signature of Provider / Authorized Business Agent

_____
Date of Signature

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Care Services Branch
601 Kamokila Blvd., Rm 506A
Kapolei, HI 96707

**(PART D)**

**EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROVIDER AGREEMENT**

I, as a Primary Care Provider (PCP) agree to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in accordance with Title 17, Chapter 1737, Subchapter 6, Section 53 to 62 of the Hawaii Administrative Rules.

I HAVE READ AND UNDERSTAND PART D OF THE AGREEMENT:

_____ _____
(Full Signature of Provider) (Date)

*(Leave Blank if New Provider)*

_____ _____
(Print Provider's Name in Full) (Medicaid Provider No.)

EFFECTIVE DATE REQUESTED:

_____

***FOR DHS OFFICIAL USE ONLY***

APPROVED: _____ _____
Provider Data Technician Date

EFFECTIVE DATE OF PROVIDER PARTICIPATION: _____
MONTH/DAY/YEAR

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Care Services Branch
601 Kamokila Blvd., Rm 506A
Kapolei, HI 96707

**(PART E)**

**DISCLOSURE INFORMATION (DI)**

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

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

| | | | |
|---|---|---|---|
| **8.** | List name, date of birth, SSN#/FEIN#, and address of each person or entity that owns 5% or more direct or indirect ownership in the applicant provider. If provider is a non-profit organization, skip to #9 (Attach extra pages if necessary.)<br>☐ *No owner has more than 5% of ownership* ☐ *Non-profit organization* | | |
| Name / Business Name: | | | SSN: |
| Business Address: | | FEIN: | DOB: |
| City: | | State: | Zip Code: |
| ** If a corporate entity is disclosed in item #8 above, all business location(s) of this corporate entity must be disclosed. Please attach a sheet to disclose this information. | | | |
| **9.** | List officers' and board members' information. (Attach extra sheet if necessary listing same details below.) ☐ *Check here for N/A* | | |
| Name (a) | | Title: | |
| Address: | | DOB: | SSN: |
| City: | | State: | Zip Code: |
| Name (b) | | Title: | |
| Address: | | DOB: | SSN: |
| City: | | State | Zip Code: |
| **10.** | If any individuals listed in items #8 and #9 are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.)<br>☐ *Check here for N/A* | | |
| Name (a) | | | SSN: |
| Relationship: | | | FEIN: |
| Name (b) | | | SSN: |
| Relationship: | | | FEIN: |
| **11.** | If this facility or organization employs a management company, please provide the following information:<br>☐ *Check here for N/A* | | |
| Name: | | | |
| Address: | | | |
| City: | | State: | Zip Code: |

| | | | |
|---|---|---|---|
| **12.** | List the names of any other disclosing entity in which person(s) listed on this application have ownership of other Medicare/Medicaid facilities. ☐ *Check here for N/A* | | |
| Name: | | Provider #, if applicable: | |
| Address: | | | |
| City: | | State: | Zip Code: |
| **13.** | List the names and addresses of all other Hawaii Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of $25,000 or 5% of your total operating expense. (Attach extra page if necessary.) ☐ *Check here for N/A* | | |
| Name: | | | |
| Address: | | | |
| City: | | State: | Zip Code: |
| **14.** | List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year periods. (Attach extra page if necessary.) ☐ *Check here for N/A* | | |
| Name: | | | |
| Address: | | | |
| City: | | State: | Zip Code: |
| **15.** | List the name, SSN, and address of any immediate family member who is authorized under Hawaii Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment. ☐ *Check here for N/A* | | |
| Name: (a) | | Title: | |
| Address: | | DOB: | SSN: |
| City: | | State: | Zip Code: |
| Name (b) | | Title: | |
| Address: | | DOB: | SSN: |
| City: | | State: | Zip Code: |
| **16.** | List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a Hawaii Medicaid provider number (s), please indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A* | | |
| Name (a) / Hawaii Medicaid Provider Number (s), if applicable: | | | |
| Name (b) / Hawaii Medicaid Provider Number (s), if applicable: | | | |

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

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Care Services Branch
601 Kamokila Blvd., Rm 506A
Kapolei, HI 96707

| | | |
|---|---|---|
| **21.** | Contact Information – This information is used only for questions regarding the information on this form. | |
| | Contact Name: | Contact Telephone: |
| | E-mail address: | |
| **22.** | I certify that all the Information I have provided on this DHS, Med-QUEST Division Disclosure of Ownership Form is accurate. Failure to provide accurate information could result in termination from the Medicaid program. | |
| | Signature | Date Signed: |
| | Printed Name: | |
| | Title: | |
| **23.** | DHS will report all monies paid to you to theirs. Please indicate which number you use for tax reporting. If enrolled as an individual and you do not own a FEIN, please complete SSN only. | |
| | Report DHS payment to my FEIN: | |
| | Report DHS payment to my SSN: | |
| Please attach copy of your IRS verification letter OR a copy of your Social Security Card verifying FEIN/SSN above. | | |
| **24.** | **FOR DHS USE ONLY:** | |
| | Signature: | Date Signed: |
| | Printed Name: | |
| | Title: | |

| | | |
|---|---|---|
| EPLS/SAM: | OIG/HHS: | SSA Death Master File: |

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

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

Date Signed

Print Name of Provider / Authorized Business Agent

Signature of Provider / Authorized Business Agent

STATE OF HAWAII
**DEPARTMENT OF HUMAN SERVICES**
Med-QUEST Division
Health Care Services Branch
601 Kamokila Boulevard, Room 506A
Kapolei, Hawaii 96707

Dear Applicant:

The Affordable Care Act (ACA) required changes to the Med-QUEST Division's (MQD) processing of provider enrollment applications. A list of these requirements is provided below.

**Beginning January 1, 2018:**

- **All providers <u>in-network</u> with a managed care health plan will need to enroll as a Medicaid provider directly with MQD.**
- **All providers that are paid FFS will need to enroll as a Medicaid provider directly with MQD.**

<u>Requirements to enroll as a Medicaid provider</u>

1. Provider screening consistent with sections 1902(a)(39), 1902(a)(77), and 1902(kk) of the Social Security Act (SSA);

2. Assures enrolled provider will be screened in accordance with 42 CFR §455.400 et seq;

3. Assures that the MQD requires all ordering or referring or prescribing physicians or other professionals to be enrolled, with this requirement extending to only in-network physicians or professionals in the managed care setting;

4. Assures that MQD has a method for verifying provider licenses by the State and that provider licenses have not expired or have current limitations;

5. Assures that providers will be revalidated at least every five (5) years;

6. Assures that MQD complies with all requirements in section 1902(a)(39) of the SSA and 42 CFR §455.416 for all terminations or denials of provider enrollment;

7. Assures that any reactivation of a provider includes re-screening and payment of application fees as required by 42 CFR §455.600;

8. Assures that all terminated providers and providers denied enrollment as a result of 42 CFR §455.416 are given appeal rights;

9. Assures that pre-enrollment and post-enrollment site visits of providers who the State and Federal government has determined are at "moderate" or "high" risk categories will occur;

10. Assures that providers or any person with an ownership or controlling interest >5% will be required to consent to criminal background checks including fingerprints for providers who the State and Federal government has determined are at "high" risk categories will occur;

11. Assures that MQD performs Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider;

12. Assures that the MQD requires that National Provider Identifier (NPI) of any ordering or referring or prescribing physician or other professional to be specified on the claim for payment that is based on an order or referral or prescription of the physician or other professional;

13. Assures that MQD complies with sections 1902(a)(77) and 1902(kk) of the (SSA) and 42 CFR §455.450 for screening levels based upon the categorical risk level determined for a provider;

14. Assures that MQD complies with the requirements for collection of the application fee set forth in section 1866(j)(2) of the SSA and 42 CFR §455.600; and

15. Assures that MQD complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under sections 1866(j)(7) and 1902(kk)(4) of the SSA;

16. Providers must submit a completed and signed Medicaid provider enrollment Form DHS 1139 and all applicable parts.

Managed Care vs. Fee-For-Service (FFS)

Managed care health plans will continue to perform credentialing of providers. Below is a list of contacts for managed care health plans that participate in the Medicaid program. Please note that the majority of Medicaid beneficiaries are provided services through these managed care plans; FFS only supports approximately 100 to 200 beneficiaries.

| *Health Plan* | *Contact Information* |
|---|---|
| AlohaCare | Provider Relations at 973-1650 or toll-free at 1-800-434-1002<br>www.alohacare.org |
| HMSA | Provider Services at 948-6486 or toll-free at 1-800-440-0640<br>www.hmsa.com |
| 'Ohana Health Plan | 1-888-846-4262 or www.ohanahealthplan.com |
| UnitedHealthcare Community Plan | 1-888-980-8728 or www.uhccommunityplan.com |

Provider Types by Categorical Risk

| Risk | Provider Types | Application Fee | Comments |
|---|---|---|---|
| Low | Physicians | No | None |
| | Non-physician practitioners | No | |
| | Medical groups or clinics except for physical therapists and physical therapy groups | Yes | |
| | Ambulatory surgery centers | Yes | |
| | End-state renal disease centers | Yes | |
| | Federally qualified health centers | Yes | |
| | Hospitals | Yes | |
| | Mammography screening centers | Yes | |
| | Pharmacies | Yes | |
| | Radiation therapy centers | Yes | |
| | Rural health clinics (RHC) | Yes | |
| | Skilled nursing facilities | Yes | |
| Moderate | Ambulance suppliers | Yes | All providers require on-site visits prior to being established as a Medicaid provider. |
| | Community mental health centers | Yes | |
| | Comprehensive outpatient rehabilitation facilities | Yes | |
| | Hospice organizations | Yes | |
| | Laboratories | Yes | |
| | Diagnostic testing facilities | Yes | |
| | Physical therapy including group | No | |
| High | Home health agencies (new and currently enrolled) | Yes | All providers require background checks to include fingerprints and on-site visits prior to being established as a Medicaid provider. |
| | Suppliers of Durable Medical Equipment and Medical Supplies (new and currently enrolled) | Yes | |
| | Home and community based service (HCBS) providers including but not limited to personal care attendant, skilled nursing, community care foster family homes (CCFFH), expanded adult residential care home | Yes | |

Application Fee

The MQD is required to obtain a $500 application fee from all providers EXCEPT for non-institutional providers. This requirement is independent of the provider risk category. A partial list of non-institutional providers include Physicians, Psychiatrists, Podiatrists, Optometrists, APRNs, Physician Assistants, RNs, Dentists, among others. Institutional providers must submit a money order or cashiers check for $500 when submitting the application, payable to:

State Director of Finance
c/o Med-QUEST Division
Health Care Services Branch, Provider Enrollment
601 Kamokila Boulevard, Room 506A
Kapolei, Hawaii 96707

MQD may rely on the results of the screening conducted by the Medicare contractor. For out of state providers, MQD may rely on the results of the screening conducted by the Medicaid agency in their home state. Providers may submit these results with their application. However, the State has the discretion to conduct its own screening.

Basic Information about Application
Please complete and sign the enclosed application. Failure to sign the application and provide the requested information may result in the application being returned without action.

Required Forms:

- ❑ **Part A (Medicaid Application/Change Request Form)**
- ❑ **Part B & C (Provider Agreement and Condition of Participation)**
- ❑ **Part E (Disclosure Information)**

Optional:

- ❑ **Part D (Early & Periodic Screening, Diagnosis, and Treatment Provider Agreement)** Applicable only to providers who provide regular medical or dental services to individuals under the age of 21.

Please submit a copy of the following with your application. Failure to provide the information below may result in a delay in the processing of your application:

- ❑ **National Provider Identifier (NPI) Notification (if applicable)**
- ❑ **Current Hawaii State License to practice in the State of Hawaii (Wallet Size or an issued letter from the Department of Consumer and Commerce Affairs)**
- ❑ **Board Specialty Certificate or Letter of Board Eligibility (if applicable). DO NOT SEND diplomas in lieu of Board Specialty Certification as these will not be accepted.**
- ❑ **Advance Practice Registered Nurse Specialty and/or American Nurses Credentialing Center Certification (if applicable). Medicaid eligibles are pediatric, family, certified nurse midwife, and behavioral health nurses. All other nurses, please refer to Appendix 1.**
- ❑ **IRS Form W-9 (Request for Taxpayer Identification Number and Certification)**
- ❑ **Drug Enforcement Administration Certificate of Registration for Controlled Substances (if applicable)**

- ❑ **Certificate from the State of Hawaii Department of Public Safety-Narcotics Enforcement Division (if applicable)**
- ❑ **Hawaii General Excise Tax License (if applicable)**
- ❑ **CLIA Certificate (certificate of accreditation for laboratory services if applicable)**
- ❑ **NCPDP Certificate (certificate of accreditation for pharmacy if applicable)**

- ❑ **CMS notification letter of provider's number from Medicare.**

**Documents Not Required:**

- Certificates of Insurance;
- Driver's License.

The following providers will also need to complete an additional form (refer to the MQD website at www.med-quest.us or call (808) 692-8099.

| | |
|---|---|
| ❍ Psychiatrist or Psychologist | Psychiatry/Psychology Credentialing Attachment (DHS 1139A) |
| ❍ Non-emergency transportation (taxi- cab) | Non-Emergency Ground Transportation – Taxi Cabs Attachment (DHS 1139B) |
| ❍ Home Health Agency | Home Health Services Attachment Form (DHS 1139C) |
| ❍ Acute Hospital | Acute Hospital Attachment Form (DHS 1139D) |
| ❍ Nursing Facility (ICF or SNF) | Nursing Facility Attachment Form (DHS 1139E) |
| ❍ ICF-MR Facility | Intermediate Care Facility For The Mentally Retarded (ICF-MR) Attachment Form (DHS 1139F) |

The following providers are required to submit a copy of the current approved certificate from the Department of Health-Office of Health Care Assurance with their application:

- ❍ Ambulatory Surgical Center
- ❍ X-Ray Supplier
- ❍ Dialysis Center
- ❍ SNF / ICF Facility
- ❍ Laboratory
- ❍ Home Health Agency
- ❍ Acute Care Facility
- ❍ ICF-MR Facility

If your application is approved you will receive a letter from the Med-QUEST Division with your new Medicaid provider number. The Medicaid Provider Manual may be found on the Med-QUEST Division website at www.med-quest.us.

If you have questions regarding the application packet, please call our office at (808) 692-8099. Questions relating to claims processing should be directed to Conduent at 952-5570 on Oahu or toll-free at 1-800-235-4378 (Option 2).

# NEW PROVIDERS
# HAWAII STATE MEDICAID PROGRAM

## DHS 1139
## (Rev. Interim 11/17)

## *INSTRUCTIONS*

## PART A

**Instructions for completing the**
**Hawaii State Medicaid Program Provider of Service Information Form (DHS 1139)**
***(www.med-quest.us)***

**NEW FEE-FOR-SERVICE (MEDICAID) or**
**MEDICARE / MEDICAID PARTICIPATION**

- ***Complete and provide ALL requested information LEGIBLY.***
- ***The application will be returned if requested information is not furnished.***
- ***Do not modify this form as this is a legal and binding contract***
- ***Attach credentialing documents***

**Check off if currently credentialed by:**
CHIP from another State.
Medicare.
Medicaid from another State (include abbreviation of other State).
*Attach credentialing documents with proof of $500 payment EXCEPT for Physicians, Psychiatrists, Podiatrists, Optometrists, APRNs, Physician Assistants, RNs and Dentists.

**Medicaid Application Type:**
Check off if a new application, 5-year re-validation, or change request.

**Group Application**
If you are applying as a NEW group provider or have a change in your Federal Tax Identification Number, checkmark the *Group* box at the top of the DHS 1139 form.

**Individual Application**
If you are applying as a NEW sole proprietor or a NEW provider working for an established group, checkmark the *Individual* box located at the top of the DHS 1139 form.

**Medicaid Fee-For-Service Provider**
An applicant, hereby after referred to as "*provider*" must circle "Y" for Medicaid Fee-For-Service Provider. Note: Claims from an approved Medicaid Fee-For-Service provider will automatically crossover to Medicaid from Medicare if the provider's Medicare number was submitted to Medicaid.

**Medicare / Medicaid Provider**
Circle "Y" if the *provider* is providing Medicare eligible services that are not covered by the Medicaid Program to individuals that are eligible as beneficiaries for both Medicare and Medicaid, also known as a Qualified Medicare Beneficiary. Some provider specialties are reimbursable by the Medicaid Program as QMB Only providers. Please refer to **Appendix 1** for definition.

## SECTION I - PROVIDER INFORMATION

| | | |
|---|---|---|
| Box 1 | National Provider Identifier | Enter the 10-digit NPI number and include the enumerator letter with the application. |
| Box 2 | Provider Name | Enter *provider's* Last Name, First Name and Middle Initial if the services will be rendered by an individual. |
| Box 3 | Provider's Registered Business Name / Doing Business As (d.b.a.) Name | Enter the applicable Provider's Registered Business Name or Doing Business As (d.b.a.) Name. Please check the appropriate box indicating the type of business venture. If "Other," please specify in the space provided, e.g., limited liability company, partnership, employee (under contract), etc. |
| Box 4 | Social Security Number | Enter the *provider's* social security number. The use of this number is for verification purposes only. |
| Box 5 | Specialty | Provide a copy of the Board Certification or Board Letter for specialty(ies). Refer to Appendix 2 |
| Box 6 | Gender | Enter male or female. |
| Box 7 | Date of Birth | Enter date of birth: month, day, year. |
| Box 8 | First Date of Service For Which a Claim Will Be Submitted | Enter the provider's first date of service for which the provider will submit a claim to the State of Hawaii Medicaid Program. Failure to provide this information may result in claims being denied. This will be the same date as the effective date. |

## SECTION II – ADDRESS INFORMATION

Please indicate by checking the appropriate box. Note: A NEW State of Hawaii Medicaid Fee-For-Service *provider* is required to have at least one (1) in-state service address location, and one (1) pay-to address location at the time of application.

### CORRESPONDENCE ADDRESS (C):

- This is the address at which the *provider* receives all inquiries or correspondences.
- Provide just one (1) correspondence location.

For additional location addresses, continue on Page 2 of the application form.

| | | |
|---|---|---|
| Box 9 | Attention To | Enter the person or department to whom all inquiries or correspondence should be addressed at the given address, if applicable. |
| Box 10 | Street Line 1 | Enter the number and street address for the *provider*. |
| Box 11 | Street Line 2 | Enter additional address information for the *provider*, if necessary (i.e. suite, building, floor, or room number). |
| Box 12 | City, State/Zip/Code | Enter the appropriate city associated with the *provider's* address information. Enter the appropriate 2-digit abbreviation identifying the state associated with the provider's address information. Enter the valid 5-digit code and 4-digit extension for the zip code associated with the *provider's* address. |

| | | |
|---|---|---|
| Box 13 | Business phone | Include business telephone number. |
| Box 14 | Business Fax Number | Include business fax number. |
| Box 15 | E-Mail Address | Electronic mailing address of provider for which provider wishes to receive General Correspondences, e.g, memorandums, newsletters, etc. |

**SERVICE ADDRESS (S):**

- This is the address at which the *provider* renders services.
- All service locations must be identified.
- For each service address, please indicate if the *provider* wishes to receive mail at the e-mail address in addition to receiving mail at the *provider's* correspondence address by checking "Y" or "N".
- A Post Office Box CANNOT be used for a service address.
- Rural service locations on the neighbor islands may add their physical location address on Street Line 1, and the Post Office Box on Street Line 2.

For additional location addresses, continue on Page 2 of the application form.

The following instructions are to be used to complete the provider's service address(es) on pages 1 and 2:

| | | |
|---|---|---|
| Box 16 | Attention To | Enter the person or department to whom all inquiries or correspondence should be addressed at the given address, if applicable. |
| Box 17 | Street Line 1 | Enter the number and street address for the *provider*. |
| Box 18 | Street Line 2 | Enter additional address information for the *provider*, if necessary (i.e. suite, building, floor, or room number). |
| Box 19 | City, State/Zip/Code | Enter the appropriate city associated with the *provider's* address information. Enter the appropriate 2-digit abbreviation identifying the state associated with the provider's address information. Enter the valid 5-digit code and 4-digit extension for the zip code associated with the *provider's* address. |
| Box 20 | Business Phone | Enter the telephone number (including area code), to be used when contacting the *provider* during normal business hours. |
| Box 21 | Fax Number | Enter the fax number (including area code), to be used when contacting the *provider* during normal business hours. |
| Box 22 | Begin Date | Enter the effective begin date for the service and pay-to address. The effective dates for both addresses must be the same as in Box 8, Section I. |
| Box 23 | End Date | Enter the effective end date for participation for the service and pay-to address when applicable. *(Indicate if making a change due to either participation or move.)* |

| | | |
|---|---|---|
| Box 24 | CLIA Number | If the service address location is for a laboratory or laboratory services will be performed at this service address location, enter the Clinical Laboratory Improvement Amendments (CLIA) Laboratory Certificate of Accreditation number. Attach a copy of the current CLIA certificate with this form. |
| Box 25 | NCPDP No. | Enter the National Council for Prescription Drug Programs (NCPDP) certificate number if the service address is for a pharmacy. Attach a copy of the certificate with this form. |

**PAY-TO ADDRESS (P):**

- This is the address to which payments for services rendered by the *provider* are to be mailed. For additional location addresses, continue on Page 2 of the application form.
- For each pay-to address, please indicate if the *provider* wishes to receive mail at the address in addition to receiving mail at the *provider's* correspondence address by checking "Y" or "N".

For addition location addresses, continue on Page 2 of the application form.

The following instructions are to be used to complete the provider's pay to address(es) on pages 1 and 2:

| | | |
|---|---|---|
| Box 26 | Attention To | Enter the person or department to whom all inquiries or correspondence should be addressed at the given address, if applicable. |
| Box 27 | Street Line 1 | Enter the number and street address for the provider. |
| Box 28 | Street Line 2 | Enter additional address information for the provider, if necessary (i.e. suite, building, floor, or room number). |
| Box 29 | City, State/Zip/Code | Enter the appropriate city associated with the provider's address information. Enter the appropriate 2-digit abbreviation identifying the state associated with the provider's address information. Enter the valid 5-digit code and 4-digit extension for the zip code associated with the provider's address. |
| Box 30 | Business Phone | Enter the telephone number (including area code), to be used when contacting the provider during normal business hours. |
| Box 31 | Fax Number | Enter the fax number (including area code), to be used when contacting the provider during normal business hours. |
| Box 32 | Begin Date | Enter the effective begin date for the service and pay-to address. The effective dates for both addresses must be the same as in Section I, Box 7. |
| Box 33 | End Date | Enter the effective end date for participation for the service and pay-to address when applicable. |

| | | |
|---|---|---|
| Box 34 | Federal Tax ID Number | 1. If the *provider* is a sole proprietor, indicate the applicable tax payer identification number to be reported on Form 1099.<br><br>2. If the *provider* is working for a Group, fill in the Federal Employer Identification Number (FEIN) for the group.<br><br>3. If the *provider* is working for another individual provider or for themselves, the applicable SSN or FEIN of the other provider is required ***(the group or employing provider must be actively participating in the State of Hawaii Medicaid Program)***.<br><br>4. If the Group is not an established Medicaid participating provider, a separate Group application must be submitted with at least one individual's application denoting the individual's participation with the new Group.<br><br>5. A copy of the Form W-9, Request for Taxpayer Identification Number and Certification, must be attached to this form and the name listed on Form W-9 form must match the Pay-To Name exactly for the associated service address location. Failure to ensure that the Pay-To Name is reported correctly may result in claims being denied. |
| Box 35 | General Excise Tax Number | 1. If the *provider* is a **sole proprietor**, indicate the applicable tax identification number (for Form 1099 reporting).<br><br>2. If the *provider* is **working for a Group**, fill in the Hawaii General Excise Tax number for the group. |

## SECTION III - ADDITIONAL INFORMATION

| | | |
|---|---|---|
| Box 36 | License/ Certificate Number | Enter the appropriate identification number for the *provider's* license(s) or certification(s). Attach a current copy of all required licenses and certificates. |
| Box 37 | Licensing/ Certifying Agency | Enter the name of the agency that issued the *provider's* license or certification, e.g., State of Hawaii Department of Commerce and Consumer Affairs (SOH/DCCA), Drug Enforcement Administration (DEA), Department of Human Services, etc. |
| Box 38 | Issue Date | If indicated, enter the date the license or certification was originally issued by the agency (MM/DD/YYYY). *Note: The license or certification must cover dates of service the provider is requesting.* |
| Box 39 | Expiration Date | If indicated, enter the date the license or certification expires (MM/DD/YYYY). |

| | | |
|---|---|---|
| Box 40 | Agent Signature | Individual(s) authorized to act as a signor on behalf of the *provider* for all Medicaid claims and claim correspondence must sign with their original signature. If additional lines are required, please attach a separate list. The provider must sign on Item 44 of this form and any additional list to indicate their approval. ***Note: The provider shall be the only person who can authorize and de-authorize an individual or individuals.*** |
| Box 41 | Print Name | Legibly print or type in the names of the individuals whose authorized signature appears in the Agent Signature field. |
| Box 42 | Begin Date | Enter the appropriate date on which the authorized agent's signature will become effective. |
| Box 43 | End Date | Not applicable if this is a new application. Enter the end date of participation with the Medicaid program. |
| Box 44 | Group Billing Authorization | Enter the name of the group billing that the provider is giving authorization to bill for him/her. |
| Box 45 | Association Begin Date | Enter the appropriate date on which the association began (or will begin) with the group practice. |
| Box 46 | Association End Date | Enter the appropriate date on which the association ended (or will end) with the group practice. |
| Box 47 | Medicare ID Number | Enter the Medicare Part B identification number assigned to the *provider* by Medicare (attach a copy if available). Note: Since a Medicare/Medicaid provider renders **services only eligible for reimbursement by Medicare,** the Medicare Part B number must be indicated in this box to enable claims crossing over by Medicare to Medicaid for payment of the client's (patient's) co-payment and/or deductible to be paid. Medicare/Medicaid applications received without this Medicare Part B number will be returned without action. |
| Box 48 | Provider Signature | This application is not valid unless signed by the *provider.*<br>• Original signature only.<br>• Stamped (facsimile) signature not accepted.<br>• Xerox copy of signature not accepted. |
| Box 49 | Date | Enter the date the *provider* signed this application. |
| Box 50 | Provider Name | Please type or print legibly the name of the individual whose signature appears in Box 47. |

**Filing Instructions for New Applicants & Updates to Provider Information:**

Mail the form and all required documents to:

**Med-QUEST Division**
**Health Care Services Branch, Provider Enrollment**
**601 Kamokila Blvd., Room 506A**
**Kapolei, Hawaii 96707**

Upon receipt of the Hawaii State Medicaid Program Provider of Service Information Form (DHS 1139), the Health Care Services Branch will:

1. Review the form in its entirety and make a determination as to your request for participation in the State of Hawaii Medicaid Program.

2. If participation is approved, a *Welcome Letter* will be mailed to the *provider* by the State relaying the 6-digit Medicaid provider root number plus the 2-digit service locator code for each service location for claims to be filed. The approved effective date of participation, as determined by the State, will also be stated.

3. Please be advised that use of your assigned 10-digit National Provider Identification (NPI) number is mandatory it shall be used on all claim forms. Failure to comply with this mandatory action will result in non-payment of claims.

Call the Health Care Services Branch at (808) 692-8099

- If there are questions regarding this form and its attachments; or,
- If additional copies of the form is needed; or if you wish to inquire on the status of your application.

# PARTS B AND C

## Instructions for completing the Agreement and Conditions of Participation

### Purpose

This section outlines the agreement and conditions to participate in the Medicaid program as required by state and federal regulations.

### Part B (Pages 5 – 6)

1. If you are an individual provider or will be employed with a group, circle 'I' and enter the name of the applicant.

2. If you are a group provider, circle 'We' and enter the name of the group or business that the application is being submitted for.

3. Paragraphs 1 – 11 states the agreements and conditions of participation for the Hawaii State Medicaid program. Please read through this section carefully.

### Part C (Pages 6 – 8)

1. Retroactive Certification (1-year retro provision):

    a. The **original** signature is required by:

        i. the submitting applicant who will be providing services; **OR**

        ii. an authorized business agent (e.g., billing agent) who will be handling claims processing;

    b. Print *legibly* name of provider/authorized business agent.

    c. Sign name of provider/authorized business agent.

    d. Enter the date signed.

## PART D

### Instructions for completing the Early and Periodic Screening, Diagnosis, and Treatment Provider (EPSDT) Agreement

**Purpose**

To provide preventive, diagnostic, and screening services for children in accordance with Title 17, Chapter 1737 of the Hawaii Administrative Rules.

1. This agreement applies only to the following provider types who will be servicing EPSDT recipients:
   a. Internal Medicine;
   b. Dental;
   c. Family Medicine.
2. Full Signature of Provider:

   The original signature is required by the submitting applicant who will be providing services **OR** an authorized business agent (e.g., billing agent) who will be handling claims processing.
3. Enter date signed.
4. Print *legibly*:
   a. Provider's name in full.
   b. Medicaid Provider No.
5. Effective Date Requested: enter the start date for participation in the Medicaid program.
6. *For DHS Official Use Only* – do not complete.

## PART E

### Instructions for completing the Disclosure Information Form

**Purpose**

The disclosure of this information to the Medicaid Agency **is a federal requirement.** The information must be furnished to the Medicaid Agency within 35 days of a written request per federal regulations (§455.104(3), §455.105(b), and §455.106). **For provider groups or sole proprietors, failure to provide accurate and complete disclosure information will render this application incomplete**.

**The Department of Human Services (DHS) may refuse to enter into a contract and may suspend or terminate an existing agreement if the provider fails to disclose ownership or controlling information and related party transactions.**

1. Definitions are listed below to assist you in completing the form.

2. If there is no information to include, check the **"Not applicable" (N/A) box**. Please do not leave sections blank. The application will be returned if this part is not filled in.

3. Sign and date the attestation. Print *legibly* the name of provider/authorized business agent.

### Annual Disclosure of Ownership (ADO) Instructions

| | **DESCRIPTION** |
|---|---|
| Box 1 | Enter name of individual or entity depending on who the Disclosure Information (DI) is in regards to. |
| Box 2 | Enter current NPI/Medicaid Provider number combination that this DI is in reference to, if applicable. |
| Box 3 | If there has been a change of ownership or a Federal Tax Identification number, list previous Medicaid provider numbers and effective dates for each, if applicable. |
| Box 4 | Describe relationship or similarities between the provider disclosing information on this form and items "A" through "C".<br>**a. Describe the relationship between the old owner and the new owner. Are they totally different owners or some of the owners the same, etc.?**<br>**b. Describe the relationship between the old board members (under old owner) and the new board members (under the new owner). Are any of the board members under the old ownership also board members under the new ownership structure?**<br>**c. Why is the old owner disenrolling? Essentially, why was there a change in ownership?** |
| Box 5 | Do you plan to have a change in ownership, management company or control within the next year? If so, when? |

| | |
|---|---|
| Box 6 | Do you anticipate filing bankruptcy? If so, when? |
| Box 7 | Enter the Federal Tax Identification Number **(if there is an affiliation with a chain)** along with name, address, city, state and zip code. |
| Box 8 | List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. ***If no one owns 5% or more of the provider entity, check box and complete item # 9 with the officers' and board members' information. If a non-profit, check box and complete item #9 with the officers' and board members' information.*** If you are enrolled as an individual and do not own a FEIN, please enter **your** name and information. Corporate entities disclosed in this question must disclose every business location. |

**Indirect Ownership Interest –** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

**Ownership Interest** – means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

**Person with an Ownership or Control Interest** – means a person or corporation that:

- Has an ownership interest totaling 5% or more in a disclosing entity;
- Has an indirect ownership interest equal to 5% or more in a disclosing entity;
- Has a combination of direct of and indirect ownership interests equal to 5% or more in a disclosing entity;
- Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% 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?

| | |
|---|---|
| Box 9 | List officers' and board members' information of the owning entities. |
| Box 10 | If applicant is related to persons listed in items #8 and #9, list the relationship. |
| Box 11 | List name of managing company, if not applicable enter N/A. |
| Box 12 | List names of the disclosing entities in which persons have ownership of other Medicare/Medicaid facilities. |

**Other Disclosing Entity** – means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII).
- Any Medicare intermediary or carrier.
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health- related services for which it claims payment under any plan or program established under Title V or Title XX or the Act.

| | |
|---|---|
| Box 13 | If entity engages with subcontractors (such as physical therapist, pharmacies, etc.,) which exceeds the lesser of $25,000 or 5% of applicant's operating expense, list subcontractor's name and address. |

Significant Business Transaction-means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5% of applicant's operating expense.

| | |
|---|---|
| Box 14 | List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. |
| Box 15 | List name, SSN, address of any immediate family member who is authorized to prescribe drugs, medicine, devices or equipment. |
| Box 16 | List anyone disclosed in item #8 who has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act (SSA) or any criminal offense in this state or any other state. Please also indicate any HI Medicaid provider number(s) associated with individual or organization. |
| Box 17 | List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the SSA or any criminal offense in this state or any other state. Indicate any HI Medicaid provider number(s) associated with individual or organization. |

**Agent** – means any person who has been delegated the authority to obligate or act on behalf of a provider.

**Managing Employee** – means 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, organization or agency.

| | |
|---|---|
| Box 18 | List the name, title, FEIN/SSN, and business address of all managing employees as defined in 42 CFR §455.101. |
| Box 19 | List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. |

| | |
|---|---|
| **Subcontractor** – means an individual, agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of provider 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 lease of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement. | |
| Box 20 | Enter your initials if you maintain electronic medical records and are HIPAA compliant. Check the box if you do not keep electronic medical records. |
| Box 21 | Please enter the contact information for OMS to contact should there be any questions regarding this form. |
| Box 22 | Signature: Enter original signature from the individual provider, owner, or officer/board member if the provider does not have an owner. If you are an individual provider, *your* signature is required.<br>Printed Name: The individual signing this form must enter their printed name.<br>Date: Enter the date this disclosure is signed.<br>Title: Must be title of person signing this form. EXAMPLE: individual provider, owner, etc. |
| Box 23 | Please indicate which number you will be using for reporting monies to you from Medicaid for 1099 purposes. *Example: If you are an individual completing this question, please input your Social Security Number unless you do not own a FEIN 100%. An individual provider can bill under his/her individual provider number even if they are working in a group selling. The individual must complete a Map-347 in order to be linked to the group selling under which they are reporting.*<br>***IRS verification letter or Social Security card must be attached verifying FEIN/SSN.* |
| Box 24 | For Internal Purposes Only: DHS Authorized Signature |

Please return form to:

Med-QUEST Division
Health Care Services Branch, Provider Enrollment
601 Kamokila Boulevard, Room 506A
Kapolei, Hawaii 96707

## ADDITIONAL DEFINITIONS FOR DISCLOSURE OF INFORMATION FORM

**"Agent"** means any person who has been delegated the authority to obligate or act on behalf of a provider.

**"Convicted"** means that a judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

**"Disclosing entity,"** means a Medicaid provider and/or Medicaid applicant.

**"Fiscal agent"** means a contractor that processes or pays vendor claims on behalf of the Department of Human Services.

**"Indirect ownership interest"** means an ownership interest in any entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

**"Managing employee"** means 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, organization or agency.

**"None"** means no information to disclose.

**"Not applicable" (N/A)** means the same as "None."

"**Other Disclosing Entity**" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid; but, is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal & Child Health Services), Title XVIII (Medicare), or Title XX (Grants to States for Social Services). This includes:

1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare.

2) Any Medicare intermediary or carrier, and

3) Any entity that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XIX (Medicaid) of the Social Security Act.

**"Ownership interest"** means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

**"Person with an ownership or controlling interest"** means a person or corporation that:

1) Has an ownership interest totaling five (5) percent or more in a disclosing entity;
2) Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;
3) Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;
4) 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;
5) Is an officer or director of a disclosing entity that is organized as a corporation; or
6) 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:

1) 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
2) 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.

**APPENDIX 1**

PROVIDER TYPES

**What is QMB?**

**"QMB Program"** means Qualified Medicare Beneficiary Program. As a result of Section 301 of the Medicare Catastrophic Coverage Act of 1988, the Department of Human Services will provide Qualified Medicare Beneficiary (QMB) coverage to recipients with Medicare coverage meeting the eligibility criteria for this program. Under this program, the State Medicaid Program will pay for the recipients' Medicare premiums, and any coinsurance and/or deductible to providers rendering services.

**"QMB-Only Provider"** means a provider who does not meet the eligibility criteria for Medicaid; but, is providing Medicare eligible services and wants to be eligible to bill for services rendered to QMB/Medicaid recipients. No payment will be made to providers not participating under the QMB Program. Claims submitted from providers not identified as a QMB or QMB-Only provider will be denied.

**"QMB/Medicaid"** means recipients with dual coverage; these recipients however must be treated as Medicaid patients. Medicare assignment must be accepted and claims will cross over to Medicaid for coordinated processing.

**"QMB Only Payments"** means payments processed for the coinsurance and/or deductible for services covered under Medicare to QMB/Medicaid recipients through the State's Medicaid fiscal agent. No payment will be made toward services not covered by Medicare even if the services are a benefit of the Medicaid Program.

**"QMB/Medicaid Payments"** means payments processed for the coinsurance and deductible for Medicare covered services to recipients with dual coverage through the State's Medicaid fiscal agent. Any service not covered by Medicare but covered under Medicaid will also be paid; however, a separate claim may need to be submitted to Medicaid for these Medicare non-covered services.

**APPENDIX 2**

SPECIALTY / DEGREE

| CODE | DESCRIPTION |
|---|---|
| 175 | ACUPUNCTURIST |
| 951 | ADDICTION MEDICINE |
| 180 | ADMINISTRATIVE MEDICINE |
| 176 | ADOLESCENT MEDICINE |
| 185 | AEROSPACE MEDICINE |
| 011 | ALLERGIST |
| 010 | ALLERGIST/IMMUNOLOGIST |
| 952 | ANATOMIC PATHOLOGY |
| 135 | ANATOMICAL/ CLINICAL PATHOLOGY |
| 020 | ANESTHESIOLOGIST |
| 925 | AUDIOLOGIST |
| 410 | BACTERIOLOGY |
| 131 | BLOOD BANKING |
| 464 | BLOOD GROUPING/RH TYPING |
| 953 | BRONCHO-ESOPHAGOLOGY |
| 927 | CARDIOLOGIST |
| 062 | CARDIOVASCULAR MEDICINE |
| 954 | CHEMICAL DEPENDENCY |
| 955 | CHEMICAL PATHOLOGY |
| 510 | CLINICAL CHEMISTRY |
| 251 | CRITICAL CARE MEDICINE |
| 501 | CROSSMATCHING |
| 809 | DENTIST - ANESTHESIOLOGIST |
| 802 | DENTIST - ENDODONTIST |
| 803 | DENTIST - ORAL PATHOLOGIST |
| 808 | DENTIST - ORAL SURGEON |
| 801 | DENTIST - ORTHODONTURE |
| 804 | DENTIST - PEDODONTIST |
| 806 | DENTIST - PERIODONTIST |
| 805 | DENTIST - PROSTHODONTIST |
| 807 | DENTIST - PUBLIC HEALTH |
| 800 | DENTIST-GENERAL |
| 040 | DERMATOLOGIST |
| 143 | DERMATOPATHOLOGY |
| 956 | DIABETES |
| 957 | DIAGNOSTIC LABORATORY IMMUNOLOGY |
| 913 | DIALYSIS |
| 504 | EKG SERVICES |
| 250 | EMERGENCY MEDICINE |

SPECIALTY / DEGREE – Continued

| CODE | DESCRIPTION |
|---|---|
| 901 | EMERGENCY ROOM PHYSICIANS |
| 063 | ENDOCRINOLOGIST |
| 540 | EXEFOLIATIVE CYTOLOGY |
| 714 | EYE (LOW VISION SPECIALIST) |
| 050 | FAMILY PRACTICE |
| 136 | FORENSIC PATHOLOGY |
| 064 | GASTROENTEROLOGIST |
| 055 | GENERAL PRACTICE |
| 019 | GENETICIST |
| 082 | GERONTOLOGIST |
| 958 | GYNECOLOGICAL ONCOLOGY |
| 090 | GYNECOLOGIST |
| 065 | HEMATOLOGIST |
| 970 | HEMATOLOGY & ONCOLOGY |
| 574 | HISTOCOMPATABILITY |
| 074 | HISTOPATHOLOGY |
| 077 | HOMEOPATHIC |
| 178 | HYPNOTIST |
| 490 | IMMUNOHEMATOLOGY |
| 012 | IMMUNOLOGIST |
| 959 | IMMUNOPATHOLOGY |
| 971 | INDUSTRIAL MEDICINE |
| 066 | INFECTIOUS DISEASES |
| 060 | INTERNAL MEDICINE |
| 122 | LARYNGOLOGIST |
| 960 | LEGAL MEDICINE |
| 092 | MATERNAL AND FETAL MEDICINE |
| 138 | MEDICAL CHEMISTRY |
| 969 | MEDICAL TOXICOLOGY |
| 400 | MICROBIOLOGY |
| 071 | MSW SOCIAL WORKER |
| 450 | MYCOLOGY |
| 096 | NEONATAL NURSE PRACTITIONER |
| 961 | NEOPLASTIC DISEASES |
| 067 | NEPHROLOGIST |
| 075 | NEUROLOGIST |
| 141 | NEUROPATHOLOGY |
| 799 | NO SPECIALTY REQUIRED |
| 080 | NUCLEAR MEDICINE |
| 081 | NUCLEAR PHYSICS |
| 962 | NUCLEAR RADIOLOGY |

SPECIALTY / DEGREE – Continued

| CODE | DESCRIPTION |
|---|---|
| 187 | NUTRITIONIST |
| 091 | OBSTETRICIAN |
| 089 | OBSTETRICIAN AND GYNECOLOGIST |
| 183 | OCCUPATIONAL MEDICINE |
| 241 | ONCOLOGIST |
| 100 | OPHTHALMOLOGIST |
| 015 | OPTICIAN |
| 600 | OPTOMETRIST |
| 532 | ORAL PATHOLOGY |
| 950 | ORTHOPEDIST |
| 972 | OSTEOPATHIC MANIPULATIVE MEDICINE |
| 161 | OSTEOPATHIC MANIPULATIVE THERAPY |
| 999 | OTHER |
| 585 | OTHER CLINICAL CHEMISTRY |
| 073 | OTHER IMMUNOHEMATOLOGY |
| 072 | OTHER MICROBIOLOGY |
| 437 | OTHER SEROLOGY |
| 120 | OTOLARYNGOLOGIST |
| 124 | OTOLOGIST |
| 935 | OTORHINOLARYNGOLOGIST (ENT) |
| 964 | PAIN CONTROL |
| 460 | PARASITOLOGY |
| 530 | PATHOLOGY |
| 967 | PATHOLOGY, RADIOISOTOPIC |
| 155 | PEDIATRIC - NEONATAL/PERINATAL MEDICINE |
| 191 | PEDIATRIC - PSYCHIATRIST |
| 157 | PEDIATRIC ALLERGIST |
| 151 | PEDIATRIC CARDIOLOGIST |
| 156 | PEDIATRIC ENDOCRINOLOGIST |
| 152 | PEDIATRIC HEMATOLOGIST |
| 963 | PEDIATRIC HEMATOLOGY-ONCOLOGY |
| 154 | PEDIATRIC NEPHROLOGIST |
| 076 | PEDIATRIC NEUROLOGIST |
| 943 | PEDIATRIC ORTHOPEDIST |
| 159 | PEDIATRIC PULMONARY DISEASE |
| 150 | PEDIATRICIAN |
| 188 | PHARMACOLOGIST |
| 160 | PHYSICAL MEDICINE/ REHABILITATION |
| 798 | PHYSICIAN ASSISTANT |
| 503 | PHYSIOLOGICAL TESTING |
| 650 | PODIATRIST |

SPECIALTY / DEGREE – Continued

| CODE | DESCRIPTION |
|---|---|
| 470 | PREGNANCY TESTING |
| 182 | PREVENTIVE MEDICINE |
| 900 | PROCEDURES - ANY CERTIFIED LABORATORY |
| 973 | PROCTOLOGY |
| 098 | PSYCH/MENTAL HEALTH NURSE PRACTITIONER |
| 192 | PSYCHIATRIST |
| 195 | PSYCHIATRIST AND NEUROLOGIST |
| 965 | PSYCHOANALYSIS |
| 083 | PSYCHOLOGIST |
| 189 | PSYCHOSOMATIC MEDICINE |
| 184 | PUBLIC HEALTH |
| 068 | PULMONARY DISEASES |
| 550 | RADIOBIOASSAY |
| 200 | RADIOLOGY |
| 201 | RADIOLOGY - DIAGNOSTIC |
| 968 | RADIOLOGY - ONCOLOGY |
| 158 | RADIOLOGY - PEDIATRIC |
| 205 | RADIOLOGY - THERAPEUTIC |
| 974 | REHABILITATION MEDICINE |
| 093 | REPRODUCTIVE ENDOCRINOLOGIST |
| 966 | RETIRED |
| 500 | RH TITERS |
| 069 | RHEUMATOLOGIST |
| 125 | RHINOLOGIST |
| 097 | RN ADULT NURSE PRACTITIONER |
| 084 | RN FAMILY NURSE PRACTITIONER |
| 088 | RN GERIATRIC NURSE PRACTITIONER |
| 094 | RN MIDWIFE |
| 086 | RN PEDIATRIC NURSE ASSOCIATE |
| 087 | RN PEDIATRIC NURSE PRACTITIONER |
| 085 | RN SCHOOL NURSE PRACTITIONER |
| 975 | ROENTGENOLOGY (DIAGNOSTIC) |
| 511 | ROUTINE CHEMISTRY |
| 976 | SCLEROTHERAPY |
| 430 | SEROLOGY |
| 162 | SPORTS MEDICINE |
| 210 | SURGERY |
| 211 | SURGERY - ABDOMINAL |
| 212 | SURGERY - CARDIOVASCULAR |
| 030 | SURGERY - COLON/RECTAL |
| 219 | SURGERY - GYNECOLOGICAL |

SPECIALTY / DEGREE – Continued

| CODE | DESCRIPTION |
|---|---|
| 213 | SURGERY - HAND |
| 214 | SURGERY - HEAD AND NECK |
| 215 | SURGERY - MAXILLOFACIAL |
| 070 | SURGERY - NEUROLOGY |
| 181 | SURGERY - OBSTETRICAL |
| 441 | SURGERY - OPTHALMOLOGICAL |
| 977 | SURGERY - ORAL & MAXILLOFACIAL |
| 110 | SURGERY – ORTHOPAEDIC |
| 153 | SURGERY - PEDIATRIC |
| 170 | SURGERY - PLASTIC |
| 171 | SURGERY - PLASTIC OTOLARYNGOLOGICAL FACIAL |
| 484 | SURGERY - PODIATRIST |
| 220 | SURGERY - THORACIC |
| 216 | SURGERY - TRAUMA |
| 217 | SURGERY - UROLOGICAL |
| 218 | SURGERY - VASCULAR |
| 431 | SYPHILIS |
| 166 | THERAPIST - OCCUPATIONAL |
| 167 | THERAPIST - PHYSICAL |
| 165 | THERAPIST - SPEECH |
| 524 | URINALYSIS |
| 230 | UROLOGIST |
| 440 | VIROLOGY |
| 095 | WOMEN'S HEALTHCARE/OB-GYN NURSE PRACTITIONER |

**APPENDIX 3**

PROVIDER TYPES

| CODE | DESCRIPTION |
|---|---|
| 50 | ADULT FOSTER CARE |
| 19 | ADVANCE PRACTICE NURSE PRACTITIONER – *LICENSE CLASS: FAMILY, PEDIATRICS, CERTIFIED MIDWIFE, BEHAVIORAL HEALTH* |
| 43 | AMBULATORY SURGICAL CENTER *(FREESTANDING)* |
| 62 | AUDIOLOGIST |
| 51 | BEHAVIORAL HEALTH COUNSELOR |
| 60 | BLOOD BANK |
| 34 | CASE MANAGEMENT SERVICES |
| 16 | CHIROPRACTOR – MEDICARE ELIGIBLE BENEFIT (QMB ONLY PROVIDER) |
| 05 | CLINIC |
| 29 | COMMUNITY/RURAL HEALTH CENTER |
| 73 | DEFAULT PROVIDER |
| 07 | DENTIST |
| D1 | DENTIST - ENDODONTIST |
| D3 | DENTIST - ORAL SURGEON |
| D2 | DENTIST – PEDODONTIST |
| 41 | DIALYSIS CLINIC (Needs COS 01 & 04) |
| 30 | DME SUPPLIER |
| 31 | DO-PHYSICIAN OSTEOPATH |
| 63 | DRUG AND ALCOHOL REHAB |
| 06 | EMERGENCY TRANSPORTATION |
| C3 | FAMILY PLANNING SERVICES |
| C2 | FEDERALLY QUALIFIED HEALTH CENTER (FQHC) |
| 01 | GROUP-PAYMENT ID - *NOTE: A PROVIDER THAT PROVIDES BILLING SERVICES OR ACTS AS A BILLING AGENT TO ONE OR MORE PROVIDERS BUT DELIVERS <u>NO DIRECT SERVICES</u> TO A PATIENT. GROUP BILLERS MAY NOT BE USED AS A SERVICING, PRESCRIBING, OR REFERRING PROVIDER. THE PROVIDER NUMBER <u>CANNOT</u> BE USED TO SUBMIT CLAIMS TO MEDICAID.* |
| 23 | HOME HEALTH AGENCY |
| 35 | HOSPICE |
| 02 | HOSPITAL – *INCLUDES ALL LEVELS OF CARE (ACUTE, SNF, ICF, SUBACUTE, PHARMACY, LAB, ETC. AS LONG AS WITHIN THE HOSPITAL* |
| 95 | INTERPRETER SERVICES |
| 04 | LABORATORY / X-RAY |
| 08 | MD-PHYSICIAN |
| 52 | MENTAL HEALTH CLINIC |
| 28 | NON-EMERGENCY TRANSPORTATION PROVIDERS |
| 46 | NURSE (PRIVATE-RN/LPN) - EXPANDED EPSDT SERVICES |
| 22 | NURSING HOME |
| 13 | OCCUPATIONAL THERAPIST |
| 69 | OPTOMETRIST |
| 03 | PHARMACY |

PROVIDER TYPES – Continued

| CODE | DESCRIPTION |
|---|---|
| 14 | PHYSICAL THERAPIST |
| 10 | PODIATRIST |
| 71 | PSYCHIATRIC HOSPITAL |
| 11 | PSYCHOLOGIST |
| 90 | QMB ONLY PROVIDER – ***PROVIDING MEDICARE ONLY ELIGIBLE SERVICES*** |
| 33 | REHABILITATION CENTER |
| 15 | SPEECH/HEARING THERAPIST |
| 79 | VISION CENTER *(OPTICIAN SERVICES)* |

**REQUEST FOR EMERGENCY PROCESSING OF A MEDICAL APPLICATION**

Re: _____ _____ __/__/__
Patient's Full Name | Sex | Date of Birth

This is to certify that the above-named patient is suffering from a medical condition which, if not treated immediately, could result in:

_____ Serious risk of disease;

_____ Serious health complications;

_____ Irreparable harm; or

_____ Threat of life or vital function of the patient.

This patient's need for medical services is based on the following diagnosis:

_____
_____
_____

The following treatments, medications, and/or medical supplies are needed immediately and will not be available to the patient until a disposition is made on the Medicaid application:

_____
_____
_____
_____

This emergent condition must be treated within _____ hours or _____ days.

The confirmation of medical conditions as requiring immediate treatment to merely facilitate the immediate processing of a person's medical application or to obtain assurances of Medicaid payment for medical care, may result in the withholding of reimbursement, disqualification from participation in the Medicaid Program and/or subject the physician to criminal sanctions. The physician is reminded of Medicaid regulations that allow coverage of allowable medical expenses for medical care provided under the Medicaid fee-for-service program no earlier than the first day of the three months prior to the patient's application for medical assistance. Under the Hawaii QUEST program, only appropriate emergency room and hospital expenses that were incurred no earlier than five days prior to the patient's application for medical assistance, may be considered for coverage.

_____ _____ _____
Signature of Physician | Printed Name of Physician | Date

_____ _____ _____
Address of Physician | Phone Number | FAX Number

DHS 1149 (Rev. 12/97)

**INSTRUCTIONS**

**DHS 1149**

**REQUEST FOR EMERGENCY PROCESSING OF A MEDICAL APPLICATION**

**PURPOSE**:

The DHS 1149 Request for Emergency Processing of a Medical Application form is to be completed by a licensed physician or dentist certifying the existence of a medical emergency and is the basis for emergency processing of medical applications.

**GENERAL INSTRUCTIONS**:

I. A licensed physician or dentist will complete the form.

   A. The physician or dentist will certify the medical condition and the need for immediate attention, describe the condition and prescribed treatment and the consequence of any delay of immediate treatment.

   B. The physician or dentist will complete and sign the bottom portion of the form.

   C. The form shall be forwarded to the DHS eligibility office at which the application for medical assistance has been or is being filed.

II. The eligibility worker upon receipt of the completed form will:

   A. Review the form to determine whether the requirements for expedited processing of an application is warranted.

   B. If warranted, complete the processing of the application within 48 hours or two working days of the receipt of the DHS 1149 form and

   C. File the DHS 1149 in the case record.