NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P.O. Box 700190
Kapolei, Hawaii 96709-0190

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 Physicians, Psychiatrists, Podiatrists, Optometrists, APRNs, Physician Assistants, RNs, and Dentists. Please 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
P. O. Box 700190
Kapolei, Hawaii 96709-0190

MANAGED CARE

MQD has been able to obtain a waiver from some of the requirements for providers of managed care health plans. Managed care health plans will perform credentialing of providers. The MQD is able to accept managed care provider credentialing to meet several of the requirements listed below. In addition, managed care health plans are not required to implement items 7, 8, 9, 13, and 14. One of the waiver of requirements is the $500 application fee. Managed care health plans do not need to accept this fee. 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 www.alohacare.org
HMSA	Provider Services at 948-6486 or toll-free at 1-800-440-0640 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

In addition, becoming credentialed with a managed care health plan allows providers to obtain access to the State of Hawaii, DHS Medicaid on Line (DMO). Please ask provider relations with any of the managed care health plans above to help with access to this.

Requirements to become a FFS provider in Hawaii

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. Assure that the MQD requires all ordering or referring physicians or other professionals to be enrolled either as a FFS provider or as a managed care provider;

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 will be required to consent to criminal background checks including fingerprints if required under State law or by the level of screening based on risk fraud, waste abuse for that category of provider;

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 physician or other professional to be specified on the claim for payment that is based on an order or referral 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.

Provider-types by Categorical Risk

Risk Level	Provider Types	Comments
Low	Physicians	Offices in Hawaii to see patients. Those without offices to see patients and performing services by telemedicine are in the moderate risk category.
	Non-physician practitioners	
	Medical groups or clinics except for physical therapists and physical therapy groups	
	Ambulatory surgery centers	
	End-state renal disease centers	
	Federally qualified health centers (FQHC)	
	Hospitals	
	Mammography screening centers	
	Pharmacies	
	Radiation therapy centers	
	Rural health clinics (RHC)	
	Skilled nursing facilities	
Moderate	Ambulance suppliers	Offices in Hawaii to see patients. Those without offices to see patients or performing services by telemedicine are in the high risk category.
	Community mental health centers	
	Comprehensive outpatient rehabilitation facilities	
	Hospice organizations	
	Laboratories	
	Diagnostic testing facilities	
	Physical therapy including group practices	
	Home health agencies (currently enrolled)	
High	Home health agencies (newly enrolling)	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)	
	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 (E-ARCH).	

All FFS providers offering services to Hawaii residents shall have an office in Hawaii that can be accessed for unscheduled or unannounced on-site visits.

MQD may rely on the results of the screening conducted by the Medicare contractor. Providers may submit their 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 Xerox at 952-5570 on Oahu or toll-free at 1-800-235-4378 (Option 2).

NEW PROVIDERS
HAWAII STATE MEDICAID PROGRAM

DHS 1139
(Rev. 02/14)

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 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 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 7, 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. 2. If the *provider* is working for a Group, fill in the Federal Employer Identification Number (FEIN) for the group. 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)***. 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. 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). 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.* • Original signature only. • Stamped (facsimile) signature not accepted. • 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
P. O. Box 700190
Kapolei, Hawaii 96709-0190

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". **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.?** **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?** **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. ***Complete item #9 with the officers' and board members' information of the owning entities. 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 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. If no one owns 5% or more and/or the provider is non-profit, the officers' and board members' information must be disclosed.
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. Printed Name: The individual signing this form must enter their printed name. Date: Enter the date this disclosure is signed. 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.* ***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
P. O. Box 700190
Kapolei, Hawaii 96709-0190

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)*