





An Independent Licensee of the Blue Cross and Blue Shield Association

Working for a Healthier Hawaii

## HMSA PROVIDER APPLICATION FORM

<b>PRIMARY LOCATION</b> (Check appropriate box): <input type="checkbox"/> Primary <input type="checkbox"/> Secondary																																																															
24. Business Location Address (include suite #/room #, city, state and zip code): <input type="checkbox"/> Do not publish this location																																																															
25. Billing/Mailing Address for Payment (include suite/room #, city, state and zip code and/or P.O. Box)																																																															
26. What arrangements in your practice ensure continuous 24-hour accessibility to dental services (i.e. emergency and vacation coverage?) Please provide name, address and telephone number of dentist(s) covering for you.																																																															
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<b>PAYMENT INFORMATION</b>																																																															
27. Name of clinic or group practice (if applicable)																																																															
28. Tax ID number of clinic or group	29. Billing NPI Number (NOTE: Payment checks will be made out to provider name or clinic/group practice associated with this NPI number.)	30. Mail payment to: <input type="checkbox"/> Billing address <input type="checkbox"/> Business location address																																																													
<b>PRACTICE INFORMATION</b>																																																															
31. Appointment phone number (will be published in website directory)	32. E-mail address (if available)	33. Fax number																																																													
34. Number of office staff that speaks languages other than English (including American Sign Language):	35. Number of office staff (including provider)	36. Handicap accessibility <input type="checkbox"/> Yes <input type="checkbox"/> No																																																													
37. <b>LANGUAGES SPOKEN</b> (Please check appropriate box(es))																																																															
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<b>NOTE: For additional locations, please submit additional copies of this page.</b>																																																															

38. Effective Date of Practice \_\_\_\_\_  
(Month/Day/Year)

39. \_\_\_\_\_  
Signature Date