



*Working for a Healthier Hawaii*

# HMSA Provider Application Form Dental Providers INSTRUCTIONS

NOTE: Please ensure that all boxes are completed. Indicate 'Not Applicable' for any fields that do not apply to you.

1. **Individual NPI** – National Provider Identifier; providers are required to obtain their NPI and use this identifier for electronic transactions beginning May 23, 2007; visit [www.cms.hhs.gov](http://www.cms.hhs.gov) for more information. Forward a copy of your NPI confirmation (e.g. hard copy letter, e-mail confirmation, etc.) if you already registered and received your NPI.
2. **Date of Birth** – self-explanatory.
3. **Gender** – self-explanatory.
4. **Provider's Full Name** – Provider's last name, first name and middle initial if you are an individual provider.
5. **Type of Degree** – Indicate if DDS or DMD.
6. **Social Security Number** – self-explanatory.
7. **Provider's Business Name** – Name you are doing business under (e.g. J. Doe, DDS, Inc. or J. Doe dba JB Dental Clinic.)
8. **Tax Identification Number** – Indicate your Tax Identification Number. Payment will be made under this number.
9. **Correspondence Address** – this address will be used to mail Provider Updates and any non-payment-related mailings).
10. **Type of Provider** – physician, psychologist, dentist, etc.
11. **Hawaii State Dental License Number** – Indicate your Hawaii State Dental License number.
12. **Date Issued/ Expiration Date** – Date initially issued and expiration date of your Hawaii State Medical License.
13. **DEA Number** – Federal Drug Enforcement Administration; indicate your Federal DEA number.
14. **DEA Expiration Date** – Indicate your Federal DEA expiration date if you are an individual provider who prescribes medication.
15. **Clinical Lab Inspection Approval (CLIA) Number** – Indicate the number assigned by Medicare if you are doing in-office lab services.
16. **CLIA Start/End Dates** – Indicate the initial start and end dates of your Clinical Lab Inspection Approval.
17. **Provider's Medicare PIN Number** – This is the Provider Identification Number (PIN) assigned to you by Medicare for Part B services for a specific location. Please provide a copy of your letter from Medicare indicating your PIN number and your Medicare par status and the effective date.
18. **Medicare Opt Out Provider** – Please check the appropriate box. Provider who has not enrolled with Medicare and whose services cannot be billed to Medicare- payment is the responsibility of the member.
19. **Graduation Date form Professional School** – Indicate month and year you obtained your basic professional degree.

20. **Controlled Substance Number and Expiration Date** – Indicate your State of Hawaii Certificate of Registration for Controlled Substances number if you are an individual provider who prescribes medication and its expiration date.
21. **Board Certification/Specialty** – All specialty dentists are required to complete this section. Indicate your primary field of practice as specialty #1. List all other specialty designations in order of preference. If applicable, complete one of the following items for each specialty: If you are board-certified, complete the board certification number as well as the certification date; if you are board eligible or completed an accredited residency program, indicate the completion date under Eligibility/Residency. Submit a copy of each board certification or documentation of eligibility or residency as indicated.
22. **Interested in participation with HMSA** – Check the appropriate box. If you check 'YES', please indicate the specialty or subspecialty under which you would like your name to appear in provider directories. Note: The specialty or subspecialty must be recognized by a specialty board and HMSA's Credentialing Unit.
23. **Programs Available** – Check whether you are interested in participating in the Preferred Provider Organization (PPO) Plan and/or Health Maintenance Organization (HMO) Plan. Participation in the HMO Plan is limited to those providers with Hawaii Dental Group.
24. **Business Location Address** – Include the suite or room number, city, state and zip code.
25. **Billing Address for Payment** – Address to which your billing and payment information will be sent. Include the suite or room number, city, state and zip code and/or P.O. Box.
26. **Arrangements in your practice to ensure continuous 24-hour accessibility to dental services** – i.e. emergency and/or vacation coverage. Please provide the name, address and telephone number of the dentist(s) covering for you.
27. **Name of Clinic or Group Practice** – Indicate the entity if you are part of a clinic or group practice.
28. **Tax Identification Number of Clinic or Group Practice** – Indicate the Tax ID of the group.
29. **Billing NPI Number** – Indicate your billing NPI. Payment checks will be made out to provider name or clinic/group practice associated with this NPI number.
30. **Mail Payment To** – Check the appropriate box.
31. **Appointment Phone number** – The number used by members to schedule appointments. This phone number will be printed in directories. This number will also serve as your contact phone number.
32. **Email Address** – if available.
33. **Fax Number** – self-explanatory.
34. **Number of office staff that speaks languages other than English (including American Sign Language)** – Indicate the number of staff members who speak a foreign language, including American Sign Language and the availability of interpreter services.
35. **Number of office staff (including provider)** – The total number of staff, including provider.
36. **Handicap Accessibility** – Indicate whether your office is accessible to individuals with disabilities.
37. **Languages Spoken** – Languages spoken by the provider and staff members in the office. Please check the appropriate box(es).
38. **Effective Date of Practice** – Indicate when your practice will be effective. For providers choosing to participate with HMSA, this date will also serve as your participation date with HMSA.
39. **Signature/Date** – Please sign and date the document.