REQUEST TO PARTICIPATE
New Non-Par to Par Participating Provider Checklist

If you are interested in becoming an HMSA Participating Provider, please complete the following information and return in the postage-paid envelope or fax to (808) 538-8996.

☑ Yes, I am interested in becoming an HMSA Participating Provider

Requested Effective Date for Participation: ______________________

Provider Name: ______________________

Individual NPI (Type 1): ______________________ Social Security Number: ______________________

Please indicate each practicing location and payment information for each location. If payment information is the same for each location, indicate, 'same as location 1'. Attach a separate sheet for more than three locations.

Practicing LOCATION 1: ______________________

Billing NPI: __________ Billing Tax ID: __________ Billing Tax ID Eff Date: __________

Billing address: ______________________

Practicing LOCATION 2: ______________________

Billing NPI: __________ Billing Tax ID: __________ Billing Tax ID Eff Date: __________

Billing address: ______________________

Practicing LOCATION 3: ______________________

Billing NPI: __________ Billing Tax ID: __________ Billing Tax ID Eff Date: __________

Billing address: ______________________

Please enclose copies of the following documents:

- W-9 Form – Request for Taxpayer Identification Number & Certification
- Liability Insurance Certification (minimum $1 million per occurrence /$1 million aggregate)
- Copy of National Provider Identifier (NPI) Enumerator confirmation

______________________ ______________________
Authorized Signature Date

HMSA Dental Services, P.O. Box 1320, Honolulu, HI 96807-1320 Phone (808) 948-6440 Fax (808) 538-8996