HMSA
FACILITY/ANCILLARY FACILITY INITIAL CREDENTIALING APPLICATION FORM

(Not applicable for Behavioral Health Programs/Facilities e.g. IOPs, Partial Hospitalization, Residential. Please complete the Behavioral Health Facility/Program Application Form)

<table>
<thead>
<tr>
<th>Facility/Program (Legal Name):</th>
<th>Business Name:</th>
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<tbody>
<tr>
<td>DBA Name (if different from business name):</td>
<td>TAX ID #:</td>
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<tr>
<td>Mailing Address:</td>
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<tr>
<td>Location Address:</td>
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<tr>
<td>County:</td>
<td></td>
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<tr>
<td>Main Phone # :</td>
<td>Main Fax #:</td>
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<tr>
<td>Website URL (if applicable):</td>
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(IF FACILITY OR ANCILLARY FACILITY HAS MORE THAN ONE LOCATION, IT MUST SUBMIT A SEPARATE APPLICATION FOR EACH LOCATION. PLEASE ATTACH ADDITIONAL APPLICATIONS TO THIS ONE.)

Please select the HMSA programs you would like to participate in:

| ☐ Preferred Provider Plan | ☐ HMO | ☐ Medicare Plans | ☐ QUEST |

Facility Type (please check correct classification):

| ☐ Free Standing Ambulatory Surgical Center | ☐ Hospice | ☐ Hospital |
| ☐ Skilled Nursing Facility | ☐ Home Health Agency | ☐ Other ______________ |

Ancillary Type (please check correct classification):

| ☐ Ambulance | ☐ Durable Medical Equipment | ☐ Hospice |
| ☐ Independent Lab | ☐ Home Health/Infusion Therapy | ☐ Medical Supplier |
| ☐ Orthotics/Prosthetics | ☐ PET Center/Imaging Centers | ☐ Pharmacy |
| ☐ Radiology, Free Standing | ☐ Sleep Study Center | Other ______________ |
If Applicable (Please attach copy):

Medicare #:_________________________ Medicaid #:________________________

Corporate Owner:

Name:_________________________________________________________________

Corporate Address:_____________________________________________________

_________________________________________________________________

Clinical Service / Management:

Name:_______________________________________________________________

Phone#:__________________________  Fax #:______________________________

Administrative Contact:

Name:_______________________________________________________________

Phone #:__________________________  Fax:_______________________________

Medical Director (Note: Medical Director must be a M.D or D.O. licensed in the State):

Not applicable for Home Health Agencies and Ancillary Providers

Name:_________________________________________________________________

Phone #:__________________________  Fax:_______________________________

Please list the key contacts at your Facility/Program: (If different from above)

Contact for Admissions:      Name:________________________ Phone#:____________

Corporate Office Contact:   Name:________________________ Phone#:____________

Medical Director:            Name:________________________ Phone#:____________

Business Office (billing):  Name:________________________ Phone#:____________

Credentialing Contact:      Name:________________________ Phone#:____________

1. List your geographic service area:

________________________________________________________________________

________________________________________________________________________
2. How is the Facility/Program licensed? (check all that apply if applicable)

☐ Hospital  ☐ Skilled Nursing Facility
☐ Home Health Agency  ☐ Free Standing Ambulatory Surgical Center
☐ Other ____________________________
☐ NA

3. Is your Facility/Program accessible to the handicapped? ☐ Yes ☐ No

4. Does your Facility/Program have a university association? ☐ Yes ☐ No

If “yes”, with which university:______________________________________________

5. Does the Facility/Program have a research component? ☐ Yes ☐ No

6. Emergency Room Services ☐ Yes ☐ No

a. If no emergency room services, which acute care Facility/Program(s) provide emergency room services?

___________________________________________________________________________

Is your relationship with them contractual? ☐ Yes ☐ No

b. Other, please specify:_____________________________________________________

7. Facility/Program License and Accreditation Information

If the facility is not accredited, a Medicare survey (current within the last 3 years) may be submitted in lieu of accreditation. If the facility is not accredited and does not have a current Medicare survey, a Facility site visit will need to be conducted by HMSA.

Please list and attach current copies of each that apply:

a. State License:

    Number:_____________ Exp. Date:_______

b. Is Facility/Program Accredited? ☐ Yes ☐ No

    If YES
    Name of accrediting organization ________________________________
    Attach copy of current certificate

    If NO
    Are there plans to be accredited? ☐ Yes ☐ No

    If YES,
    Date of expected accreditation ________________________________
    By whom ________________________________

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If NO, please explain below.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

C. Below, please list any other licenses or certifications that the Facility/Program has acquired. **Include current copies of each.** If you need more space, please use a separate sheet of paper.

License Name:____________________  Number:_________  Exp. Date:_______

License Name:____________________  Number:_________  Exp. Date:_______

8. **Liability Information:** (Please include a current copy of malpractice face sheet with this application). **The limits of liability cannot be lower than $1 Million per occurrence and $1 Million in the aggregate annually.**

   a. Carrier
   Name:_________________________________________________________

   b. Policy
   Number:_______________________________________________________

   c. Coverage
   Limits:_________________________________________________________

   d. Expiration Date:_____________________________________________

9. **Malpractice Claim and Restrictive Action History.**

   **Please attach detailed information for “Yes” answers:**

   A. Has the Facility/Program or any shareholders/owners/partners ever been named in any malpractice action?  □ Yes  □ No

   B. Has the Facility/Program or any shareholders/owners/partners ever had or currently have pending any legal action?  □ Yes  □ No

   C. Has the Facility/Program or any shareholders/owners/partners ever had professional liability insurance refused, declined, canceled or accepted on special terms?  □ Yes  □ No

   D. Has any government agency ever investigated, suspended, revoked, or taken action against your license to conduct business?  □ Yes  □ No

   E. At any time, has any license or certification been revoked, reduced, denied, or suspended by others or voluntarily given up by the program, or are any actions which may lead to such conclusions under way?  □ Yes  □ No
F. At any time, have any memberships in professional organizations ever been revoked, reduced, denied, or suspended by others or voluntarily given up by the program, or are any actions which may lead to such conclusions under way? □ Yes □ No

G. Has the Facility/Program or any shareholders/owners/partners ever been convicted of a crime, excluding misdemeanors? □ Yes □ No

H. Has the Facility/Program ever been assessed a penalty, conviction or suspension or is the Facility/Program currently under investigation by a Medicaid or Medicare program? □ Yes □ No

I. Number of Claims (check one)
   0   1   2   3   (more)   

10. Has your facility/program/staff ever been excluded and/or sanctioned by any Federal health programs? □ Yes □ No
    If yes, please attach detailed information to explain the reason(s) for the exclusion and/or sanction.

11. Facility/Program Evaluation (not applicable for ancillary providers):
    a. Does the Facility/Program conduct regular quality assurance reviews?
       □ Yes □ No

    b. Does the Facility/Program conduct regular quality reviews for utilization management?
       □ Yes □ No

    If “yes”, how often do they occur?  Quality/effectiveness:_________________________
                                       Utilization Management:_________________________

    c. Please send a written sample of your guidelines for measuring quality/effectiveness and utilization management. (Preferably, copies of policy/procedure manuals, reports and any lists of the standards that the Facility/Program is measured against).

    d. If “No” was checked, specify the criteria that is used to evaluate Facility/Program quality/effectiveness.
       ___________________________________________________________________________
       ___________________________________________________________________________
       ___________________________________________________________________________
FACILITY/PROGRAM’S ATTESTATION AND DISPUTE RESOLUTION AGREEMENT

Facility certifies that all of the above information is true, complete and accurate to the best of its information, knowledge and belief. Facility further understands that providing any false, incomplete or inaccurate information in conjunction with this application may be grounds for denial of the credentialing application.

Facility hereby authorizes HMSA or its agents, to verify and release any and all of the information contained herein as may be necessary to evaluate its application to become a provider with HMSA.

Facility hereby agrees to the following dispute resolution procedures:

If facility disagrees with any decision or action by HMSA arising out of or relating to this Application or HMSA’s credentialing process, facility shall submit a written request for arbitration to HMSA’s Legal Services in Honolulu, Hawaii, within 30 calendar days following its receipt of HMSA’s credentialing decision. If facility does not submit a written request for arbitration within 30 calendar days, HMSA’s decision is final.

HMSA and facility agree that any and all claims, disputes, or causes of action arising out of or related to this Application or its performance, or arising out of or related to HMSA’s credentialing process, including but not limited to any and all claims, disputes, or causes of action based upon contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration as set forth in this document.

The arbitration of disputes shall be conducted in Honolulu, Hawaii by an independent arbitration service mutually selected by HMSA and facility. If HMSA and facility are unable to agree upon an arbitration service within thirty (30) calendar days of HMSA’s receipt of its request for arbitration, Dispute Prevention and Resolution, Inc. ("DPR") will conduct the arbitration. If HMSA and facility are unable to agree upon an arbitrator within thirty (30) calendar days following the submission of the claim to the arbitration service, then the two parties shall select an arbitrator in accordance with DPR’s arbitration selection procedures.

The arbitration will be conducted pursuant to the Hawaii Uniform Arbitration Act, HRS ch. 658A and the arbitration service’s arbitration rules, (or such other arbitration rules as the parties may mutually agree); to the extent not inconsistent with the arbitration provisions in this Application. In the arbitration, both parties shall have the right to be represented by an attorney or other person of their choice; to have a record made of the proceeding, copies of which may be obtained upon payment of any reasonable charges associated with their preparation; to call, examine and cross-examine witnesses; to present evidence determined to be relevant by the arbitrator, regardless of its admissibility in a court of law; and to submit a written statement at the close of the hearing.

Upon completion of the arbitration hearing, the arbitrator shall issue his or her written decision in the form of a recommendation to HMSA, including a statement of the basis for the recommendation. HMSA will issue a written decision consistent with the arbitrator's recommendation, including a statement of the basis for the decision. The arbitrator may hear and determine motions for summary disposition pursuant to HRS 658A-15(b). The arbitrator shall also hear and determine any challenges to the arbitration agreement and any disputes regarding whether a controversy is subject to an agreement to arbitrate. In order to make the arbitration hearing fair, expeditious and cost-effective, discovery by both parties shall be limited to requests for production of documents material to the claims or defenses in the arbitration. Limited depositions for use as evidence at the arbitration hearing may occur as authorized by HRS §658A-17(b). Each party will pay its own attorney and witness fees, provided that the arbitrator may award attorney fees and costs in an amount authorized by law to a prevailing

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party related to any claim or contention of a nonprevailing party, that the arbitrator determines was frivolous or wholly without merit. Fees and costs of the arbitrator and the arbitration service may be awarded by the arbitrator as the arbitrator determines is appropriate. If no award is made, fees and costs of the arbitrator and the arbitration service shall be shared equally by both parties. The decision of the arbitrator shall be final and binding on HMSA and facility, and judgment shall be entered thereon upon a timely motion by either party in a court of competent jurisdiction. No action may be brought in any court in connection with the dispute or award, except as provided under the Hawaii Uniform Arbitration Act. There shall be no consolidation of parties in the arbitration proceeding. The arbitrator may award any remedy that can by law be granted by a court in like circumstances, provided that no award of punitive damages or exemplary damages shall be made. The parties shall take appropriate measures to protect the confidentiality of any credentialing, quality assurance, and personal health information related to the dispute and arbitration proceeding.

______________________________________________________________________________

Print Name

______________________________________________________________________________

Title

______________________________________________________________________________

Authorizing Signature

______________________________________________________________________________

Date