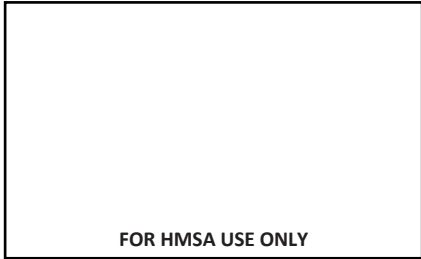




An Independent Licensee of the Blue Cross and Blue Shield Association



ADDITIONAL LOCATION FORM

To add a new practice location to your existing location(s) — **practitioners only.**

REQUIRED INFORMATION

Provider Name: _____ Social Security Number (last four digits only): _____

National Provider Identifier (NPI) Number: _____ HMSA Provider ID Number: _____
(Indicate your *individual* NPI, **not** your clinic's or group's NPI.)

NEW PRACTICE LOCATION (Indicate the physical address; no PO Boxes.) †

Name of Entity, Clinic, or Group Practice (if applicable): _____

What's your affiliation with the entity, clinic, or group (if applicable)? Owner Employed Contracted

Federal Tax ID Number: _____ NPI Number: _____
 TYPE 1 TYPE 2

Street Address: _____ *EFFECTIVE DATE: _____

City: _____ State: _____ ZIP: _____

IMPORTANT NOTE: If your payment information (remittance address, tax ID number, NPI number, etc.) has also changed, please complete the **Payment Change Form** and submit it with this form.

Is this your primary practice location? Yes No, my primary location is:

Don't list this location in HMSA's directories. At this location, indicate if you'll be a Primary Care Provider Specialist

If you're a participating provider, check all of the boxes that apply to this location:

	Accepting New Patients	Established Patients Only	Not Participating
PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MEDICARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
QUEST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VA Network ⁽¹⁾	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(1) Veterans Affairs Patient-Centered Community Care

Appointment Phone Number: _____ Contact Phone Number: _____
(Will be published in HMSA directories.) (Will be published in HMSA directories if Appointment Phone Number isn't provided.)

Fax Number: _____ Fax Number (referrals): _____ Email Address: _____

Office Manager Name: _____ Office Manager's Phone Number: _____

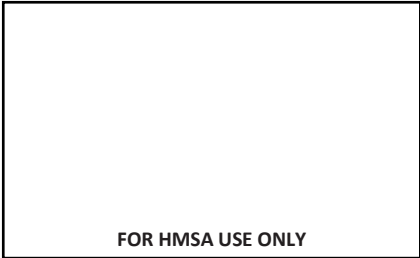
Would you like to receive notifications, memos, and letters via the email address you provided above? Yes No

PHYSICIAN ASSISTANT INFORMATION (If applicable.)

Name of supervising physician at this location: _____

† **PT, OT, SP, and MNT** – If you're adding a location to a group or individual practice that's not already contracted with Medicare, include a letter from the Centers for Medicare & Medicaid Services (CMS) that describes your participation status with Medicare.

* A future effective date (MM/DD/YY) is required to complete this request. If you leave any applicable Effective Date fields blank, we'll use the effective date you wrote elsewhere on the form. If you don't provide an effective date anywhere on the form, your request may be delayed.



FOR HMSA USE ONLY

MAILING ADDRESS (If applicable. Note that the mailing address you indicate here will be applied to all of your practice locations.)

Name of Entity, Clinic, or Group Practice (if applicable): _____

Address: _____ *EFFECTIVE DATE: _____

City: _____ State: _____ ZIP: _____

OTHER OFFICE INFORMATION (Please complete if applicable. If there are no changes, leave blank.)

Number of office staff (including provider): _____ Number of staff who speak languages other than English: _____

Languages spoken (check all that apply):

- | | | | |
|---|--|---|---|
| Provider/Staff | Provider/Staff | Provider/Staff | Provider/Staff |
| <input type="checkbox"/> / <input type="checkbox"/> Cantonese | <input type="checkbox"/> / <input type="checkbox"/> Japanese | <input type="checkbox"/> / <input type="checkbox"/> Tagalog | <input type="checkbox"/> / <input type="checkbox"/> Other |
| <input type="checkbox"/> / <input type="checkbox"/> French | <input type="checkbox"/> / <input type="checkbox"/> Korean | <input type="checkbox"/> / <input type="checkbox"/> Thai | _____ |
| <input type="checkbox"/> / <input type="checkbox"/> German | <input type="checkbox"/> / <input type="checkbox"/> Mandarin | <input type="checkbox"/> / <input type="checkbox"/> Tongan | _____ |
| <input type="checkbox"/> / <input type="checkbox"/> Hawaiian | <input type="checkbox"/> / <input type="checkbox"/> Samoan | <input type="checkbox"/> / <input type="checkbox"/> Vietnamese | _____ |
| <input type="checkbox"/> / <input type="checkbox"/> Ilocano | <input type="checkbox"/> / <input type="checkbox"/> Spanish | <input type="checkbox"/> / <input type="checkbox"/> Sign Language | _____ |

Does this practice location have access to interpreter services? Yes No

Is this location accessible to people with disabilities? Yes No

Office Hours	MON	TUES	WED	THURS	FRI	SAT	SUN

PROVIDER SIGNATURE (signature & date is required to process request)

If I have signed this Additional Location Form electronically, it means I acknowledge and agree to the terms of this Additional Location Form and so indicate by typing my name below as my electronic signature, executed and adopted by me with the intent to sign this document [- in other words, typing my name as an electronic signature indicates I acknowledge and agree to the terms of this form just as a handwritten signature would on a traditional paper form].

Signature _____

Date _____

SEND COMPLETED FORMS TO:

Mail Provider Data Administration, Room 509
HMSA
P.O. Box 860
Honolulu, HI 96808-0860

Email provider_data@hmsa.com
Fax 948-8210 on Oahu
Phone 952-7847 on Oahu or 1 (800) 603-4672 X7847
toll-free on the Neighbor Islands

*A future effective date (MM/DD/YY) is required to complete this request. If an effective date field is left blank, the same effective date will be applied to all requests on this form.