Participating in the TRICARE West Region Network as an Applied Behavior Analysis Provider

Thank you for your interest in partnering with Health Net Federal Services, LLC (HNFS) as an applied behavior analysis (ABA) provider in the Autism Care Demonstration (ACD).

Before you begin filling out the *Applied Behavior Analysis Provider Demographics Form* (located on page 2), please review the requirements detailed on this page and complete the *Affirmation of Provider Eligibility* (located on page 3).
Note: ACD information and requirements can also be reviewed at **www.tricare-west.com/go/ACD-provider**.

Applied Behavior Analysis Provider Types Subject to Credentialing

- Board Certified Behavior Analyst® (BCBA®)
- Board Certified Behavior Analyst® – Doctoral (BCBA-D®)
- Board Certified Assistant Behavior Analyst® (BCaBA®)
- Qualified Autism Services Practitioner (QASP®)
- Licensed behavior analyst (LBA)
- Licensed assistant behavior analyst (LaBA)

Applied Behavior Analysis Provider Types Subject to Certification

- Registered Behavior Technician® (RBT®)
- Applied Behavior Analysis Technician (ABAT®)
- Board Certified Autism Technician (BCAT)

Mandatory Requirements for All Applied Behavior Analysis Types

(Important: Do not submit the materials listed in this section with your *Affirmation of Provider Eligibility*. You will not submit the materials in this section until you submit your completed *Provider Participation Agreement/Provider Participation Packet*.)

- Copies of criminal history background checks (CHBCs) to HNFS. CHBCs must include:
  – Current federal, state and county criminal and sex offender reports.
  – All locations in which you have resided or worked during the previous 10 years.
- Have a National Provider Identifier (NPI).
- Provide Basic Life Support (BLS) and Cardiopulmonary Resuscitation (CPR) certification to HNFS. Accepted BLS/CPR certification classes include:
  – In-person courses (100%), or
  – Hybrid in-person and online courses.

Important: Certifications from classes that are 100% online/without any in-person training **will not** be accepted.

- Use the *Network TRICARE Provider Roster* template for all roster submissions and updates. The template is available at **www.tricare-west.com** > *Provider > Resources > Forms > Network Providers > Network TRICARE Provider Roster*.
- Will complete ACD annual training requirements (applies to Autism Corporate Services Providers [ACSPs] and ABA sole providers).
- Provide HNFS with proof of current professional liability insurance in the amounts of one million dollars per claim and three million in aggregate. Professional liability insurance must also be maintained in an ACSP's/ABA sole provider's name.
- Enroll in electronic funds transfer (EFT) for claims reimbursement (applies to Autism Corporate Services Providers [ACSPs] and ABA sole providers).

Note: You will submit your completed *Applied Behavior Analysis Provider Demographics Form* (page 2) and *Affirmation of Provider Eligibility* (page 3) as email attachments to **ACDNetwork@hnfs.com**.

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Applied Behavior Analysis Provider Demographics Form

General Information

1. Check the contract type you are requesting.
   - ☐ Applied behavior analysis (ABA) services only
   - ☐ ABA and physical health services
   - ☐ ABA and mental health services
   - ☐ ABA, mental health and physical health services

2. Select your applicable ABA provider type.
   - ☐ ABA sole provider
   - ☐ Autism Corporate Services Provider (ACSP)

3. If you selected ACSP, how many ABA providers are in your ACSP group? ____________________

4. Select the West Region state(s) in which you have an active license to practice.
   - ☐ Alaska
   - ☐ Arizona
   - ☐ California
   - ☐ Colorado
   - ☐ Hawaii
   - ☐ Idaho
   - ☐ Iowa (except Rock Island Arsenal area)
   - ☐ Kansas
   - ☐ Minnesota
   - ☐ Missouri (except St. Louis area)
   - ☐ Montana
   - ☐ Nebraska
   - ☐ Nevada
   - ☐ New Mexico
   - ☐ North Dakota
   - ☐ Oregon
   - ☐ South Dakota
   - ☐ Texas (Amarillo, Lubbock and El Paso areas only)
   - ☐ Utah
   - ☐ Washington
   - ☐ Wyoming

Practice Information

1. Practice/Doing Business As (DBA) Name: ____________________
2. Practice/DBA Physical Address (Street address, Suite/No.; City, State, ZIP code): ____________________
3. POC Business Title: ____________________
4. POC Email Address: ____________________
5. POC Phone Number: ____________________

Tax Identification/National Provider Identifier Information Numbers

1. Tax Identification Number (TIN): ____________________
2. National Provider Identifier (Practice Owner): ____________________
3. National Provider Identifier (Organization/Location): ____________________

Credentialing Information

1. Point of Contact (POC) Name: ____________________
2. POC Phone: ____________________
3. POC Fax: ____________________
4. POC Email: ____________________

Legal Information

1. Legal Notice POC Name (Person signing contract): ____________________
2. Legal Notice POC Address: ____________________
3. Legal Notice POC Phone: ____________________
4. Legal Notice POC Fax: ____________________
5. Legal Notice POC Email: ____________________

Business Owner Information

1. Business Owner Name: ____________________
2. Business Owner Phone: ____________________
3. Business Owner Email: ____________________

Affirmation of Provider Eligibility and Applied Behavior Analysis Provider Demographics Form Submission

Submit your completed A*ffirmation of Provider Eligibility* (below) and *Applied Behavior Analysis Provider Demographics Form* (page 2) as email attachments to **ACDNetwork@hnfs.com**.

Important: Please use the subject line "Applied Behavior Analysis Provider Demographics Form and Affirmation of Provider Eligibility" in the Subject field of your email.

Please keep copies of your completed *Affirmation of Provider Eligibility* and *Applied Behavior Analysis Provider Demographics Form* for your records.

Upon review, HNFS will contact you to let you know your eligibility status and any next steps.

Affirmation of Provider Eligibility

☐ By checking this box, I agree that I understand and affirm that I meet the Autism Care Demonstration (ACD) program requirements and can provide the materials listed on page 1 with my completed *Provider Participation Agreement/Provider Participation Packet*; and, if I am determined eligible to participate in the ACD, I agree to complete ACD annual training.

First and Last Name (Printed): ______________________________

Signature: ______________________________

Date Affirmation Signed: ________________

Note: You will submit your completed *Affirmation of Provider Eligibility* (above) and *Applied Behavior Analysis Provider Demographics Form* (page 2) as email attachments to **ACDNetwork@hnfs.com**.

You can also email **ACDNetwork@hnfs.com** with any questions you have concerning any part of this *Network Participation: Request*.

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