# TRICARE NON-NETWORK
# AUTISM CARE DEMONSTRATION CORPORATE SERVICE PROVIDER (ACSP) PROVIDER APPLICATION

**Instructions for completing the application:**

- Complete the group application demographic information page.
- Using the ASCP Group Member Listing, list all practitioners with their name, SSN, NPI, Specialty, and the date they joined the group.
- For each practitioner, complete the appropriate TRICARE certification requirements section. Please note, TRICARE requirements are specific to the provider type and complete information is required to ensure each practitioner meets TRICARE requirements. Failure to provide complete information will negatively impact claims payment.
- ACSP providers must enter into the enclosed participation agreement.

**Please submit the completed application package to:**

**Fax: 1-844-730-1373**

**or**

**Mail to:**

**TRICARE West**
**Provider Data Management**
**PO Box 202106**
**Florence, SC 29502-2106**

*Health Net Federal Services offers payments and remittances by National Provider Identifier (NPI) number.* ***The NPI billed on the claim will determine where payment and remittance will be sent.*** *It is critical the information provided matches how your office will file claims. Inconsistent data will negatively impact claims payment.*

*If your business requires multiple mailing/payment addresses, please provide an NPI for each.* ***If you have more than one NPI, you must complete a separate application for each NPI number.***

# TRICARE Non-Network Application
# Autism Care Demonstration Corporate Service Provider (ACSP)

Autism Care Demonstration Corporate Service Provider (ACSPs) include individual Board Certified Behavior Analyst (BCBA), Board Certified Behavior Analyst–D (BCBA-D) and Licensed Behavior Analyst (LBA), ABA licensed/certified provider, autism centers, autism clinics that contract or employ Assistant Behavior Analysts, and Behavior Technicians (BTs).

ACSP Name: _____

Federal Tax Number: _____

ACSP NPI#: _____

Physical Location (Street Address):

_____

_____

_____

Telephone #: _____

Fax #: _____

Billing Address for this NPI (If different):

_____

_____

_____

Telephone #: _____

Billing Fax #: _____

Date legal entity established: _____
(mm/dd/yyyy)

Will each practitioner sign their own claim form _____ Yes _____ No

If No, Signature Authorization forms are attached. Please complete these forms and have them notarized for each practitioner. Without signature authorization forms on file, each claim will require a physical signature from the rendering provider and claims without signature will be returned without processing the claim for payment.

**ACSP Requirements**

- ACSP must submit evidence that professional liability insurance in the amounts of 1 million dollars per claim and 3 million dollars in aggregate is maintained in the ACSP's name, unless state requirements specify greater amounts;

- ACSP must comply with all applicable organization and individual licensing or certification requirements that are extant in the State, county, municipality, or other political jurisdiction in which ABA services are provided under Autism Care Demonstration;

- ACSP must certify that all authorized ABA Supervisors, Assistant Behavior Analysts, and Behavior Technicians employed by or contracted with the ACSP meet the education, training, experience, competency, supervision and Autism Care Demonstration requirements specified in TRICARE Operations Manual (TOM) Chapter 18, Section 4;

- ACSP must maintain all applicable business licenses and employment or contractual documentation in accordance with Federal, State, and local requirements, and the authorized ABA Supervisor's business policies regarding, Assistant Behavior Analysts, and BTs;

- ACSP submit documents necessary to support an application for designation as a TRICARE ACSP, must enter into a Participation Agreement and meet all requirements set forth in TRICARE Operations Manual (TOM) Chapter 18, Section 4;

- ACSP must submit claims electronically on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form in accordance with the TOM Chapter 18, Section 4;

- ACSPs must submit a copy of the completed Criminal History Background Check (CHBC) that includes Federal, State, County Criminal and Sex Offender reports for all locations these providers have resided or worked during the previous 10 years for all authorized ABA Supervisors, Assistant Behavior Analysts and BTs.

- ACSP must submit a copy of the completed training for Basic Life Support (BLS) or a Cardiopulmonary Resuscitation (CPR) equivalent certification, as demonstrated by completion of a hybrid course comprised of a web based instruction component and live component to demonstrate skills on a dummy. Any course that is done entirely in person is also acceptable.

- ACSP ABA claims are required to be reimbursed via electronic funds transfer (EFT). To set up a new EFT account, complete and submit an EFT authorization agreement found on the website www.tricare-west.com.

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TRICARE®

# ACSP MEMBER LISTING

Please list all BCBA, BCBA-D, LBA, Assistant Behavior Analysts and Behavior Technicians affiliated with your ACSP. Provider payments and remittances are issued at the NPI level; therefore, additional EFT Forms do **NOT** need to be submitted for each member.

PLEASE COMPLETE ALL REQUIRED INFORMATION.

| | PROVIDER NAME (LAST, FIRST, MID) | SSN NUMBER | NPI NUMBER | PRIMARY SPECIALTY | DATE JOINED GRP |
|---|---|---|---|---|---|
| 1. | _____ | _____ | _____ | _____ | _____ |
| | LICENSE NUMBER: _____ | ORIGINAL DATE: _____ | | EXPIRATION DATE: _____ | |
| 2. | _____ | _____ | _____ | _____ | _____ |
| | LICENSE NUMBER: _____ | ORIGINAL DATE: _____ | | EXPIRATION DATE: _____ | |
| 3. | _____ | _____ | _____ | _____ | _____ |
| | LICENSE NUMBER: _____ | ORIGINAL DATE: _____ | | EXPIRATION DATE: _____ | |
| 4. | _____ | _____ | _____ | _____ | _____ |
| | LICENSE NUMBER: _____ | ORIGINAL DATE: _____ | | EXPIRATION DATE: _____ | |
| 5. | _____ | _____ | _____ | _____ | _____ |
| | LICENSE NUMBER: _____ | ORIGINAL DATE: _____ | | EXPIRATION DATE: _____ | |
| 6. | _____ | _____ | _____ | _____ | _____ |
| | LICENSE NUMBER: _____ | ORIGINAL DATE: _____ | | EXPIRATION DATE: _____ | |
| 7. | _____ | _____ | _____ | _____ | _____ |
| | LICENSE NUMBER: _____ | ORIGINAL DATE: _____ | | EXPIRATION DATE: _____ | |
| 8. | _____ | _____ | _____ | _____ | _____ |
| | LICENSE NUMBER: _____ | ORIGINAL DATE: _____ | | EXPIRATION DATE: _____ | |

PLEASE PHOTOCOPY THIS FORM IF YOU HAVE MORE THAN EIGHT PROVIDERS.

Revised: 6/24/2021

**For each Board Certified Behavior Analyst (BCBA/BCBA-D) and Licensed Behavior Analyst (LBA) working for the ACSP, the following is required:**

Provider Name: _____

1. **Attach a copy of your Master's or Doctoral Degree.**

   Date Graduated: _____ (mm/yyyy)  Degree Earned: _____

   Name of University: _____

2. **Are you state licensed or certified to provide ABA services?** _____ Yes _____ No

   License Number: _____

   Original License Date: _____ (mm/dd/yyyy) Expiration Date: _____ (mm/dd/yyyy)

   *Attach a copy of State license or certification

3. **If state does not offer Licensure, are you certified by the Behavioral Analyst Certification Board (BACB)?**

   BACB Certification Number: _____

   Original Certification Date: _____ (mm/dd/yyyy) Expiration Date: _____ (mm/dd/yyyy)

   **Attach a copy of BACB certification.*

4. **Must have completed training for Basic Life Support (BLS) or Cardiopulmonary Resuscitation (CPR) equivalent certification, as demonstrated by completion of a hybrid course comprised of a web-based instruction component and live component to demonstrate skills on a dummy. Any course that is done entirely in person is also acceptable.**

   Date Completed: _____ (mm/dd/yyyy)

   **Attach a copy of BLS/CPR certification.*

5. **Must have a completed Criminal History Background Check (CHBC) that includes Federal, State, County Criminal and Sex Offender reports for all locations the provider has resided or worked during the previous 10 years;**

   **Attach a copy of the Criminal History Background Check (CHBC)*

6. **Have you ever been convicted of a felony**? _____ Yes _____ No

**For each Assistant Behavior Analysts [Board Certified Assistant Behavior Analyst (BCaBA), Qualified Autism Services Practitioner (QASP) or Licensed Assistant Behavior Analyst (LABA)] working for the ACSP, the following is required:**

Provider Name: _____

1. **Attach a copy of your Bachelor's Degree.**

   Date Graduated: _____ (mm/yyyy) Degree Type: _____

   Name of University: _____

2. **Are you state licensed or certified to provide ABA services?** _____ Yes _____ No

   License Number: _____

   Original License Date: _____ (mm/dd/yyyy) Expiration Date: _____ (mm/dd/yyyy)

   **Attach a copy of State license or certification*

3. **If your state does not offer Licensure, are you certified by the Behavioral Analyst Certification Board (BACB) or by the Qualified Applied Behavior Analysis Credentialing Board (QABA)?**

   Certification Number: _____

   Original Certification Date: _____ (mm/dd/yyyy) Expiration Date: _____ (mm/dd/yyyy)

   **Attach a copy of BACB/QABA certification*.

4. **Must have completed training for Basic Life Support (BLS) or Cardiopulmonary Resuscitation (CPR) equivalent certification, as demonstrated by completion of a hybrid course comprised of a web-based instruction component and live component to demonstrate skills on a dummy. Any course that is done entirely in person is also acceptable.**

   Date Completed: _____ (mm/dd/yyyy)

   **Attach a copy of BLS/CPR certification*

5. **Must have a completed Criminal History Background Check (CHBC) that includes Federal, State, County Criminal and Sex Offender reports for all locations the provider has resided or worked during the previous 10 years;**

   **Attach a copy of the Criminal History Background Check (CHBC)*

6. **Have you ever been convicted of a felony?** _____ Yes _____ No

**For each Behavior Technician (BT) working for the ACSP, the following is required:**

Provider Name: _____

1. **All Behavior Technicians must possess one of the following credentials**:

- ❑ Registered Behavior Technician (RBT) credential from the Behavior Analyst Certification Board (BACB) OR
- ❑ Applied Behavior Analysis Technician (ABAT) credential from the Qualified Applied Behavior Analysis (QABA) credentialing board OR
- ❑ Board Certified Autism Technician (BCAT) credential from the Behavioral Intervention Certification Council (BICC)

**Attach a copy of credential*

2. **Must have completed training for Basic Life Support (BLS) or Cardiopulmonary Resuscitation (CPR) equivalent certification, as demonstrated by completion of a hybrid course comprised of a web-based instruction component and live component to demonstrate skills on a dummy. Any course that is done entirely in person is also acceptable**.

   Date Completed: _____
   (mm/dd/yyyy)

   **Attach a copy of BLS/CPR certification*

3. **Must have a completed Criminal History Background Check (CHBC) that includes Federal, State, County Criminal and Sex Offender reports for all locations the provider has resided or worked during the previous 10 years;**

   **Attach a copy of the Criminal History Background Check (CHBC)*

4. **Have you ever been convicted of a felony**? _____ Yes _____ No

# TRICARE Non-Network Participation Agreement for Autism Care Demonstration (ACD) Corporate Services Provider (ACSP)

Name of ACSP: _____

Office Address: _____

_____

Telephone: _____

Tax ID Number: _____

NPI Number: _____

# ARTICLE 1

# RECITALS

## 1.1 IDENTIFICATION OF PARTIES

This Comprehensive Autism Care Demonstration Corporate Services Provider (ACSP) Participation Agreement ("Participation Agreement") is between the United States of America (USA) through the Defense Health Agency (DHA), an agency of the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) and _____, doing business as _____ (hereinafter "ACSP").

## 1.2 AUTHORITY FOR ACSPs AS TRICARE-AUTHORIZED PROVIDERS

The authority to designate ACSPs as authorized TRICARE providers resides with the Department of Defense (DoD) Demonstration authority under 10 USC 1092. This authority ceases upon termination of the Comprehensive Autism Care Demonstration Project ("Demonstration") as determined by the Director, DHA, or designee.

## 1.3 PURPOSE OF PARTICIPATION AGREEMENT

The purpose of this Participation Agreement is to:

(a) Establish the undersigned ACSP as an authorized provider of Applied Behavior Analysis (ABA) services;

(b) Establish the terms and conditions that the undersigned ACSP must meet to be an authorized provider under the Demonstration.

# ARTICLE 2

# REFERENCES

## 2.1 REQUIREMENTS

By reference, the requirements set forth in the TRICARE Operations Manual (TOM), Chapter 18, Section 4, are incorporated into this Participation Agreement and shall have the same force and effect as if fully set out herein. In addition, the provider must:

(a) Attend an annual provider education provided by the TRICARE Managed Care Support Contractors (MCSCs), Uniformed Services Family Health Plans (USFHP) Designated Providers (DPs), or the TRICARE overseas contractor.

(b) Incorporate discharge summaries and planning into every treatment plan. The provider cannot abruptly stop/terminate services for any reason to a beneficiary. All discharges or cessation of services require a minimum of a 30 calendar day transition/discharge plan.

(c) If the ACSP terminates services with any beneficiary for any reason, the ACSP must notify the contractor a minimum of 45 calendar days prior to termination.

2.2 GENERAL AGREEMENT

(a) The undersigned ACSP agrees to render clinically appropriate ABA services to eligible beneficiaries as specified in the TOM, Chapter 18, Section 4.

(b) Comply with all applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/copayment may be expected.

(c) Signing of this Participation Agreement attests that the ACSP has reviewed and agrees to comply with the requirements set forth in TOM, Chapter 18, Section 4.

## ARTICLE 3

## REIMBURSEMENT

3.1 Claims for Demonstration services will be submitted electronically on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form by the ACSP in accordance with the TOM, Chapter 18, Section 4.

3.2 The ACSP shall:

(a) Submit claims to the appropriate TRICARE contractor, USFHP DP, or TRICARE overseas contractor in accordance with the TOM, Chapter 18, Section 4; and

(b) Collect the sponsor cost-share in accordance with TOM, Chapter 18, Section 4; and

(c) Not bill the sponsor/beneficiary for:

(1) Services for which the provider is entitled to TRICARE reimbursement; and

(2) Services not clinically necessary and appropriate for the clinical management of the presenting illness, injury, or disorder;

(3) Services for which a provider would be entitled to payment but for a reduction or denial in payment as a result of quality review; and

(4) Services that are denied or recouped due to provider non-compliance with all applicable requirements in the TOM, Chapter 18, Section 4.

3.3 All claims for Demonstration services will be paid by electronic funds transfer.

## ARTICLE 4

## RECORDS AND AUDIT PROVISIONS

4.1 The ASCP grants the Director, DHA [or authorized representative(s)], the right to conduct on-site or off-site reviews or audits with full access to patients and records. The audits will be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit/ review includes, but is not limited to, the right to:

(a) Examine fiscal and all other records of the ACSP which would confirm compliance with this agreement and designation as an authorized ACSP under the ACD.

(b) Conduct audits of ACSP records including administrative and clinical records to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided to beneficiaries. The Director, DHA, or a designee shall have full access to records of TRICARE beneficiaries.

4.2 RECORDS REQUESTED BY DHA

Upon request, the ACSP shall furnish DHA or a designee such records, including administrative and medical records, that would allow DHA or a designee to determine the quality and cost-effectiveness of care rendered.

4.3 FAILURE TO COMPLY

Failure to allow audits/reviews and/or to provide records constitutes a material breach of this agreement. It may result in denial or reduction of payment, termination of this agreement pursuant to Article 5, and any other appropriate action by DHA.

## ARTICLE 5

## TERM, TERMINATION, AND AMENDMENT

5.1 TERM

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated or superseded as specified herein.

5.2 TERMINATION OF AGREEMENT BY DHA

(a) The Director, DHA, or designee, may terminate this agreement upon written notice, for cause, if the ACSP is found not to be in compliance with the provisions set forth in TOM, Chapter 18, Section 4, or is determined to be subject to the administrative remedies involving fraud, abuse, or conflict of interest as set forth in 32 CFR 199.9. Such written notice of termination shall be an initial determination for purposes of the appeal procedures set forth in 32 CFR 199.10.

(b) In addition, the Director, DHA, or designee, may terminated this agreement without cause by giving the ACSP written notice not less than 45 calendar days prior to the effective date of such termination.

5.3 TERMINATION OF AGREEMENT BY THE ACSP

The ACSP may terminate this agreement by giving the Director, DHA, or designee, written notice not less than 45 calendar days prior to the effective date of such termination. Effective the date of termination, the ACSP will cease being a TRICARE-authorized provider of Demonstration services. Subsequent to termination, an ACSP may be reinstated as a TRICARE-authorized provider of Demonstration services only by entering into a new Participation Agreement.

5.4 AMENDMENT BY DHA

(a) The Director, DHA, or designee, may amend the terms of this Participation Agreement by giving 120 calendar days notice in writing of the proposed amendment(s) except when necessary to amend this agreement from time to time to incorporate changes to the TOM, Chapter 18, Section 4 and 32 CRF 199. When changes or modifications to this agreement result from changes to the 32 CFR 199 through rulemaking procedures, the Director, DHA, or designee, is not required to give 120 calendar days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective.

(b) An ACSP who does not accept the proposed amendment(s), including any amendment resulting from changes to TOM, Chapter 18, Section 4 and 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the ACSP notice of intent to terminate its participation is not given at least 30 calendar days prior to the effective date of the proposed amendment(s), the proposed amendment(s) shall be incorporated into this agreement for services furnished by the ACSP between the effective date of the amendment(s) and the effective date of termination of this agreement.

## ARTICLE 6

## EFFECTIVE DATE

6.1 DATE SIGNED

This Participation Agreement is effective on the date signed by the Director, DHA, or designee.

DHA: _____

By: Signed Name and Title

ACSP: _____

By: Signed Name and Title

Executed on_____, 20____

_____ (TIN)

_____ (NPI)

# PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

State of _____

County of _____

_____ being first duly sworn, deposes and says: I hereby authorize PGBA, LLC / Health Net Federal Services in the state of South Carolina to accept my facsimile or stamp signature shown below

*(Facsimile, stamp or computer generated signature as it will appear on the claim form.)*

as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the TRICARE payment system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

_____
Signature

Subscribed and sworn to before me this _____ day of _____ 20____.

_____
Notary Public in and for

_____ County, State of _____

(SEAL)

My Commission expires _____

# PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

State of _____

County of _____

Know all persons by these presents:

That I, _____ have made, constituted and appointed and by these presents do make constitute and appoint _____ my true and lawful attorney-in-fact for me and in my name place and stead to sign my name on claims, for payment for services provided by me submitted to TRICARE. My signature by my said attorney-in-fact includes my agreement to abide by the TRICARE payment system concept and the remainder of the certification appearing on all TRICARE claim forms. I hereby ratify and confirm all that my said attorney-in-fact shall lawfully do or cause to be done by virtue of the power granted herein.

In witness whereof I have hereunto set my hand this _____day of _____ 20___.

_____
Signature

Subscribed and sworn to before me this _____ day of _____ 20____.

_____
Notary Public in and for

_____ County, State of _____

(SEAL)

My Commission expires _____