ACD Basic Life Support (BLS)/CPR Requirement Form
Non-Network Providers

Provider First Name_____ Provider Last Name_____

TAX ID: _____ NPI: _____

Date this provider began practicing with this group: _____

Provider Category:

- ❑ BCBA-D
- ❑ BCBA
- ❑ LABA
- ❑ BCaBA
- ❑ QASP
- ❑ RBT
- ❑ ABAT
- ❑ BCAT

REQUIREMENT:

Must have a BLS or CPR equivalent certification from a live course (not a Web-based program) that includes practice on a dummy. **Please attach a copy of certification.*

_____ _____
ASCP Representative Name Group Tax ID

_____ _____
ASCP Representative Signature Date

Please fax or mail the completed form to PGBA, LLC:

Fax: 844-730-1373

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

Revised: 6/8/2021