Autism Care Demonstration 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
- ❑ LBA
- ❑ LABA
- ❑ BCaBA
- ❑ QASP
- ❑ RBT
- ❑ ABAT
- ❑ BCAT

REQUIREMENT:

Must complete the 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.
**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

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