TRICARE NON-NETWORK CLINICAL PSYCHOLOGIST PROVIDER APPLICATION

*We expect providers to submit claims electronically. If it is necessary to submit a paper claim, the only acceptable forms are the approved **red and white** NUCC 1500 (02-12) form and the NUBC UB-04 (CMS -1450) forms. These forms must include the instructions on the back page.*

Please submit the completed application package to:

Fax: 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 Clinical Psychologist Application

First Name: _____ MI: ____ Last Name: _____

Gen: _____ Title: _____

Social Security #: _____ NPI#: _____

Are you employed by the US Government? _ Yes ____ No

Do you sign your own claim forms? ____ 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.

Do you maintain a solo practice? ___ Yes ___ No

Solo Practice Information

Solo Practice Tax ID: _____ NPI#: _____

Date you began using this Tax ID #: (mm/dd/yyyy) _____

Solo Physical Address (Street Address):

_____

_____

_____

Solo Billing Address for this NPI:

_____

_____

_____

Telephone #: _____

Fax #: _____

Billing Telephone #: _____

Email: _____

Do you work with an established group practice or institution? ____ Yes ____ No

Group Practice Information

If you practice at multiple locations, please provide the information below for each location.

Group Practice Name: _____

Group Practice Tax ID #: _____ NPI#: _____

Effective date of the group's Tax ID number or EIN (Date legal entity established): _____
(mm/dd/yyyy)

Date you began practicing with this group number: _____
(mm/dd/yyyy)

Group Physical Address (Street Address):

_____

_____

_____

Group Billing Address for this NPI:

_____

_____

_____

Telephone #: _____

Fax #: _____

Billing Telephone #: _____

Email: _____

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To certify you as a **Clinical Psychologist**, please provide the following information to confirm you meet TRICARE requirements. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Licensure: *licensed or certified by the state for the independent practice of psychology*

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Education: *Has a doctoral degree in psychology from a regionally accredited university*

Date Graduated: _____ Degree Earned: _____
(mm/yyyy)
Name of University: _____

In addition to **Licensure** and **Education**, please complete one of the following:

Clinical Experience: *Has completed two years supervised clinical experience in psychological health services of which at least one year is post-doctoral and one year (may be the post-doctoral year) is in an organized psychological health service training program*

_ _ Yes _ _ No Date Experience Requirements Met: _____
(mm/yyyy)

National Register of Health Services Providers in Psychology: *A provider who does not qualify as an authorized clinical psychologist is to be offered the alternative of applying for provider status under another mental health provider category or of applying for listing in the National Register of Health Service Providers in Psychology.*

Are you listed in the National Register of Health Service Providers in Psychology?
_ _ Yes _ _ No

If yes, name of category: _____

*Please attach a copy of your registration

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

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 _____

Revised: 12/6/2018

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 _____

Revised: 12/6/2018