TRICARE NON-NETWORK PROVIDER APPLICATION

LACTATION CONSULTANT (LC)
CERTIFIED LACTATION COUNSELOR (CLC)
CERTIFIED LABOR DOULA (CLD)

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.***

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TRICARE Non-Network Individual 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):

_____

_____

_____

Telephone #: _____

Fax #: _____

Solo Billing Address for this NPI:

_____

_____

_____

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):

_____

_____

_____

Telephone #: _____

Fax #: _____

Group Billing Address for this NPI:

_____

_____

_____

Billing Telephone #: _____

Email: _____

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To certify you as a **Lactation Consultant / Certified Lactation Counselor,** 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.

18 Years of Age: _____Yes _____No

Licensure, if offered by state:

License Number: _____

Original License Issue Date: _____ Expiration Date: _____

Are you licensed as an RN? _____Yes _____No

RN License Number: _____

Original License Issue Date: _____ Expiration Date: _____

****Attach a copy of State license***

Certification: *(*Select applicable certification)

_____ International Board of Lactation Consult Examiners (IBCLC) as a Certification Lactation Consultant

_____ Academy of Lactation Policy and Practice, Inc. (ALPP) as an Advanced Lactation Consultant or an Advanced Nurse Lactation Consultant

_____ Academy of Lactation Policy and Practice, Inc. (ALPP) as a Certified Lactation Counselor

Certification Number: _____

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

Attach a copy of certification

CPR: Must have a current adult, child and infant Cardiopulmonary Resuscitation (CPR) certification

Date Complete: _____ ***Attach a copy of certification***
(mm/dd/yyyy)

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: _____

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To certify you as a **Certified Labor Doula,** 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.

18 Years of Age: _____Yes _____No

Licensure, if offered by state: ***Attach a copy of State license***

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Education: Has attended a minimum of 24 education hours remote synchronous or asynchronous online courses or in-person courses to include:

- The physiology of labor
- Labor doula training
- Antepartum doula training
- Postpartum doula training
- Attended one or more breastfeeding courses
- Attended one or more childbirth classes

Experience: Within the last three years:

- Provided continuous in-person childbirth support for at least three childbirths as the primary labor doula supporting the birthing parent, with a minimum of 15 hours over the three childbirths
- At least two of the three births were a vaginal birth
- Provided antepartum and postpartum support for at least one birth

NOTE: *Certified Labor Doula (CLD) education and experience components cannot be obtained during CLD's own childbirth or the childbirth of an immediate family member*

Certification: Holds a current certification obtained within the last three years from one of the following organizations: ***Attach a copy of certification***

- ☐ BirthWorks International
- ☐ Childbirth and Postpartum Professional Association
- ☐ Doulas of North America (DONA) International
- ☐ International Childbirth Education Association
- ☐ National Black Doula Association
- ☐ ToLABOR

Certification Number: _____

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

****Certification requirements waived if provider participates in state Medicaid doula program.**

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State Medicaid Participation: Actively participating in a Medicaid doula program in a state with an active, permanent statewide doula Medicaid benefit and practicing only within that state. **Attach evidence of active state Medicaid participation.**

Medicaid State Participating: _____ Medicaid Number (if applicable): _____

Original Medicaid Participation Date: ___ Medicaid Participation Expiration Date: _____

CPR: Must have a current adult, child and infant Cardiopulmonary Resuscitation (CPR) certification
Date Complete: _____ ***Attach a copy of certification***
(mm/dd/yyyy)

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: _____

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TRICARE PARTICIPATION AGREEMENT FOR CERTIFIED LABOR DOULA PROVIDERS

In order to receive payment under TRICARE, _____dba _____ as the provider of services agrees:

1. Not to charge a beneficiary for the following:

   a) Services for which the provider is entitled to payment from TRICARE;

   b) Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements;

   c) Services not medically necessary and appropriate for the clinical management of the presenting illness, injury, disorder or maternity;

   d) Services for which a beneficiary would be entitles to payment but for a reduction or denial in payment as a result of quality review; and

   e) Services rendered during a period in which the provider was not in compliance with one or more conditions or authorization:

2. To comply with applicable provisions of 32 CFR 199 and related TRICARE policy;

3. To accept the TRICARE determined allowable payment combined with the cost-share, deductible, and other health insurance amounts payable by, or on behalf or, the beneficiary, as full payment for TRICARE allowed services;

4. To collect from the TRICARE beneficiary those amounts that the beneficiary has a liability to pay for the TRICARE deductible and cost-share/copayment;

5. To permit access by the Director, DHA, or designee, to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state or private agencies or organizations;

6. To provide to the Director, DHA or designee (e.g., Managed Care Support Contractor), prompt written notification of the provider's employment of an individual who, at any time during the twelve months preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly, for decisions regarding Department of Defense payments to the provider;

7. To cooperate fully with a designated utilization and clinical quality management organization which has a contract with the Department of Defense for the geographic area in which the provider renders services;

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

9. To maintain clinical and other records related to individuals for whom TRICARE payment was made for services rendered by the provider, or otherwise under arrangement, for a period of 60 months from the date of service;

10. To maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, the methods, modalities or means of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation or treatment;

11. To refer TRICARE beneficiaries only to providers with which the referring provider does not have an economic interest, as defined in 32 CFR 199.2;

12. To limit services furnished under arrangement to those for which receipt of payment by the TRICARE authorized provider discharges the payment liability of the beneficiary; and

13. Meet such other requirements as the Secretary of Defense may find necessary in the interest of health and safety of the individuals who are provided care and services.

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Defense Health Agency (DHA) agrees to:

Pay the above-named provider the full allowable amount less any applicable double coverage, cost-share/copayment, and deductible amounts.

This agreement shall be binding on the provider and DHA upon acceptance by the Deputy Director, DHA, or designee.

This agreement shall be effective until terminated by either party. The effective date shall be the date the agreement is signed by DHA.

This agreement may be terminated by either party by giving the other party written notice of termination. The provider shall also provide written notice to the public. Such notice of termination is to be received by the other party no later than 45 days prior to the date of termination. In the event of transfer of ownership, this agreement is assigned to the new owner, subject to the conditions specified in this agreement and pertinent regulations.

Certified Labor Doula:

_____
Signature

_____
Printed Name

_____
Printed Title

Executed on _____, 20_____

_____
TIN

_____
NPI

DHA OR Designee:

_____
Signature

_____
Printed Name

_____
Printed Title

Executed on _____, 20_____

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 _____

Note: Only required for non-electronic claim filers

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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 _____

Note: Only required for non-electronic claim filers

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