TRICARE NON-NETWORK CERTIFIED MARRIAGE AND FAMILY THERAPIST 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.*

In addition to a completed application, TRICARE requires all Certified Marriage and Family Therapists to enter into the enclosed participation agreement. Also, copies of state licensure, proof of education and documentation of supervised clinical experience are required by TRICARE for certification.

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.***

Note: Associate members or student members of the AAMFT are not eligible for consideration as authorized certified marriage and family therapists.

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TRICARE Non-Network Licensed Marriage and Family Therapist 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: _____

Revised: 12/6/2018

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To certify you as a **Certified Marriage and Family Therapist,** 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.

Home Address (Street Address): Emergency Telephone Number

_____ _____

_____

Licensure: (please select your specialty)

Certified Marriage and Family Therapist:
If licensure/certification as a marriage and family therapist is offered by the jurisdiction in which the provider is practicing, it is required in all cases, even if the jurisdiction offers it on an optional basis.

License/Certification Number: _____

Original License/Certification Date: _____ Current Expiration Date: _____

Please attach a copy of your license

In jurisdictions that **do not offer specific licensure or certification for marriage and family therapists, the provider must be certified or be eligible for full clinical membership in, the American Association for Marriage and Family Therapy (AAMFT), the national association that sets standards for the profession. If a provider is eligible for full clinical membership in the AAMFT but is not a member, he/she **must submit documentation** obtained from the AAMFT of such eligibility.*

_ _ I have attached proof of membership as a full Clinical member of the American Association for Marriage and Family Therapy (AAMFT).

Or

_ _ I have attached proof that I meet the requirements to become a full CLINICAL member of the AAMFT. (Membership information for the AAMFT can be obtained by calling the AAMFT at 703-838-9808)

Education: *has at least a master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline*

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

Name of University: _____

TRICARE requires a copy of your transcript which includes the name and address of the educational institution.

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Clinical Experience:

_ _ Two hundred (200) hours of approved supervision in the practice of marriage and family, ordinarily to be completed in a 2-to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases;

AND

_____ 1,000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases;

OR

_____ 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3- year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years;

AND

_____ 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling under approved supervision, involving at least 20 cases.

Required Clinical Experience Details:

Dates of clinical experience: _____ to _____
(mm/yyyy) (mm/yyyy)

Supervisor Name: _____

Name of Institution: _____

Address of Institution: _____

_____

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 MARRIAGE AND FAMILY THERAPISTS

_____

Name of Certified marriage and family therapist

_____

Office Address

_____

Telephone

_____

Tax ID Number

ARTICLE 1
RECITALS

1.1 Identification of Parties

This Participation Agreement is between the United States of America through the Department of Defense, Defense Health Agency (hereinafter DHA), a field activity of the Office of the Secretary of Defense, the administering activity for the Defense Health Agency (hereinafter DHA) and

_____,

doing business as _____,

(hereinafter designated certified marriage and family therapist(s).

1.2 Authority for Certified marriage and family therapists as Authorized Providers

32 Code of Federal Regulations Part 199 provides for cost-sharing of services provided by certified marriage and family therapists under certain conditions.

1.3 Purpose of Participation Agreement

The purpose of this participation agreement is to:

(a) Establish the undersigned certified marriage and family therapist as an authorized provider of mental health services;

(b) Establish the terms and conditions that the undersigned certified marriage and family therapist must meet.

1.4 Billing Number

The certified marriage and family therapist's billing number for all mental health services rendered is the certified marriage and family therapist's social security number or employer's identification number (EIN). This billing number must be used until the provider is officially notified by DHA of a change. The certified marriage and family therapist's number is shown on the face sheet of this agreement. It is the only billing number that will be accepted by DHA claims processors after the effective date of this agreement for becoming an authorized certified marriage and family therapist.

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ARTICLE 2
PERFORMANCE PROVISIONS

2.1 General Agreement

The certified marriage and family therapists agrees to render medically necessary and appropriate covered mental health services within the scope of his practice and licensure to eligible beneficiaries as required by this participation agreement and the 32 CFR 199.6. The terms and conditions of 32 CFR 199.6 applicable to the participation or treatment of beneficiaries by the certified marriage therapists are incorporated herein by reference.

2.2 Licensure and Certification Requirements

The certified marriage and family therapist certifies and attaches hereto documentation that:

(a) He/she is now licensed or certified to practice as a marriage and family

Therapists by the state in which practicing; or

(b) If practicing in a state which does not provide specific licensure or certification, the certified marriage and family therapist must be certified eligible for full clinical membership in the American Association for Marriage and Family Therapy; and

(c) He/she has a recognized graduate professional education with a minimum of an earned master's degree from an accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(d) He/she has the following experience:

(1) Either 200 hours of approved supervision in the practice of marriage and family counseling, ordinarily to be completed in a 2- to 3- year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

(2) 1000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases; or

(3) 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2 to 3 year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

(4) 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling under approved supervision, involving at least 20 cases.

2.3 The certified marriage and family therapist agrees that, having an exclusive election to participate as a certified marriage and family therapist, he or she will not be authorized in any other category of extra medical provider, either during or subsequent to the period this agreement is in effect.

ARTICLE 3
PAYMENT PROVISIONS

3.1 Determined Allowable Charge

The determined allowable charge is the maximum amount that can be authorized for services rendered by an authorized individual professional provider of care. The determined allowable charge is determined following the provisions set forth in 32 CFR 199.14.

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3.2 Determined Allowable Charge as Payment in Full.

The certified marriage and family therapist agrees to accept the determined allowable charge as payment in full for services rendered to beneficiaries, except applicable deductible and cost-shares.

3.3 Hold Harmless

The certified marriage and family therapist agrees to hold eligible beneficiaries harmless for non-covered care (i.e., certified marriage and family therapist may not bill a beneficiary for non-covered care and may not balance bill the beneficiary for amounts above the determined allowable charge).

ARTICLE 4

TERM, TERMINATION AND AMENDMENT

4.1 Term

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated by either party.

4.2 Termination of Agreement by DHA

The Executive Director, DHA, or designee, may terminate this agreement upon written notice, for cause, if the certified marriage and family therapist is found not to be in compliance with the provisions set forth in 32 CFR 199.6, 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.

4.3 Termination of Agreement By the Certified marriage and family therapist

The certified marriage and family therapist may terminate this agreement by giving the Executive Director, DHA, or designee, written notice of such intent to terminate at least 60 days in advance of the effective date of termination. Effective the date of termination, the certified marriage and family therapist will no longer be recognized as an authorized provider, and reinstatement shall be disallowed for any other category of extramedical individual provider. Subsequent to termination, the certified marriage and family therapist may only be reinstated as an authorized extramedical provider by entering into a new participation agreement as certified marriage and family therapist.

4.4 Amendment by DHA

(a) The Executive Director, DHA or designee, may amend the terms of this participation agreement by giving 120 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 32 CFR 199. When changes or modifications to this agreement result from changes to the 32 CFR 199 through rulemaking procedures, the Executive Director, DHA or designee, is not required to give 120 days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective.

(b) The certified marriage and family therapist, not wishing to accept the proposed amendment(s), including any amendment resulting from the changes to the 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the certified marriage and family therapist notice of intent to terminate its participation is not given at least 60 days *prior* to the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into this agreement for services furnished by the certified marriage and family therapist between the effective date of the amendment(s) and the effective date of termination of this agreement.

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ARTICLE 5
EFFECTIVE DATE

5.1 Date Signed

This participation agreement is effective on the date signed by the Executive Director, DHA, or designee.

DHA	Certified Marriage and Family Therapist
_____	_____
By: Signed Name	By: Signed Name
_____	_____
Title	Title
_____	_____
Print Name	Print Name
Executed on _____, 20____	Date Signed: _____

_____ _____
(TIN) (NPI)

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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

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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 _____

Revised: 12/6/2018

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