TRICARE NON-NETWORK SOLO
AUTISM CARE DEMONSTRATION (ACD)
BOARD CERTIFIED BEHAVIOR ANALYST (BCBA/BCBA-D)
and LICENSED BEHAVIOR ANALYST (LBA)
PROVIDER APPLICATION

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 Solo Autism Care Demonstration (ACD)
(BCBA, BCBA-D and LBA) 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 #: _____	Billing Telephone #: _____
Fax #: _____	Email: _____

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

If yes, please complete the TRICARE Non-Network Autism Care Demonstration Corporate Service Provider (ACSP) Provider Application.

To certify you as a **Board Certified Behavior Analyst (BCBA/BCBA-D) or Licensed Behavior Analyst (LBA),** please provide the following information to confirm you meet TRICARE requirements. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. Failure to provide complete and accurate information will negatively impact claims payment.

1. **Attach a copy of your Master's or Doctoral Degree.**

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

   Name of University: _____

2. **Are you state licensed or state certified to provide ABA services?** ☐ Yes ☐ No

   License Number: _____

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

   *Attach a copy of State license or certification

3. **If state does not offer Licensure, are you certified by the Behavioral Analyst Certification Board (BACB)?** ☐ Yes ☐ No

   BACB Certification Number: _____

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

   *Attach copy of BACB certification.

4. Must have completed 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.

   Date Completed: _____ (mm/dd/yyyy)

   *Attach copy of certification

5. **Attach a copy of your professional liability insurance in the amounts of one million dollars per claim and three million dollars in aggregate.**

6. **The Participation Agreement and Background Check Form needs to be completed, signed and returned with the application.**

TRICARE Non-Network Participation Agreement for Autism Care Demonstration (ACD) (BCBA/BCBA-D/LBA) Sole Provider Practice

Name of Sole Provider: _____

Office Address: _____

_____

Telephone: _____

Tax ID Number: _____

NPI Number: _____

ARTICLE 1

RECITALS

1.1 IDENTIFICATION OF PARTIES

This Comprehensive Autism Care Demonstration Sole Provider Participation Agreement ("Participation Agreement") is between the United States of America (USA) through the Defense Health Agency (DHA), an agency of the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) and _____, doing business as _____ (hereinafter "Sole Provider").

1.2 AUTHORITY FOR SOLE PROVIDERS AS TRICARE-AUTHORIZED PROVIDERS

The authority to designate Sole Providers as authorized TRICARE providers resides with the Department of Defense (DoD) Demonstration authority under 10 USC 1092. This authority ceases upon termination of the Comprehensive Autism Care Demonstration Project ("Demonstration") as determined by the Director, DHA, or designee.

1.3 PURPOSE OF PARTICIPATION AGREEMENT

The purpose of this Participation Agreement is to:

(a) Establish the undersigned Sole Provider as an authorized provider of Applied Behavior Analysis (ABA) services;

(b) Establish the terms and conditions that the undersigned Sole Provider must meet to be an authorized provider under the Demonstration.

ARTICLE 2

REFERENCES

2.1 REQUIREMENTS

By reference, the requirements set forth in the TRICARE Operations Manual (TOM), Chapter 18, Section 4, are incorporated into this Participation Agreement and shall have the same force and effect as if fully set out herein. In addition, the provider must:

(a) Attend an annual provider education provided by the TRICARE Managed Care Support Contractors (MCSCs), Uniformed Services Family Health Plans (USFHP) Designated Providers (DPs), or the TRICARE overseas contractor.

(b) Incorporate discharge summaries and planning into every treatment plan. The provider cannot abruptly stop/terminate services for any reason to a beneficiary. All discharges or cessation of services require a minimum of a 30 calendar day transition/discharge plan.

(c) If the Sole Provider terminates services with any beneficiary for any reason, the Sole Provider must notify the contractor a minimum of 45 calendar days prior to termination.

2.2 GENERAL AGREEMENT

(a) The undersigned Sole Provider agrees to render clinically appropriate ABA services to eligible beneficiaries as specified in the TOM, Chapter 18, Section 4.

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

(c) Signing of this Participation Agreement attests that the Sole Provider has reviewed and agrees to comply with the requirements set forth in TOM, Chapter 18, Section 4.

ARTICLE 3

REIMBURSEMENT

3.1 Claims for Demonstration services will be submitted electronically on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form by the Sole Provider in accordance with the TOM, Chapter 18, Section 4.

3.2 The Sole Provider shall:

(a) Submit claims to the appropriate TRICARE contractor, USFHP DP, or TRICARE overseas contractor in accordance with the TOM, Chapter 18, Section 4; and

(b) Collect the sponsor cost-share in accordance with TOM, Chapter 18, Section 4; and

(c) Not bill the sponsor/beneficiary for:

(1) Services for which the provider is entitled to TRICARE reimbursement; and

(2) Services not clinically necessary and appropriate for the clinical management of the presenting illness, injury, or disorder;

(3) Services for which a provider would be entitled to payment but for a reduction or denial in payment as a result of quality review; and

(4) Services that are denied or recouped due to provider non-compliance with all applicable requirements in the TOM, Chapter 18, Section 4.

3.3 All claims for Demonstration services will be paid by electronic funds transfer.

ARTICLE 4

RECORDS AND AUDIT PROVISIONS

4.1 The Sole Provider grants the Director, DHA [or authorized representative(s)], the right to conduct on-site or off-site reviews or audits with full access to patients and records. The audits will be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit/ review includes, but is not limited to, the right to:

(a) Examine fiscal and all other records of the Sole Provider which would confirm compliance with this agreement and designation as an authorized Sole Provider under the ACD.

(b) Conduct audits of Sole Provider records including administrative and clinical records to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided to beneficiaries. The Director, DHA, or a designee shall have full access to records of TRICARE beneficiaries.

4.2 RECORDS REQUESTED BY DHA

Upon request, the Sole Provider shall furnish DHA or a designee such records, including administrative and medical records, that would allow DHA or a designee to determine the quality and cost-effectiveness of care rendered.

4.3 FAILURE TO COMPLY

Failure to allow audits/reviews and/or to provide records constitutes a material breach of this agreement. It may result in denial or reduction of payment, termination of this agreement pursuant to Article 5, and any other appropriate action by DHA.

ARTICLE 5

TERM, TERMINATION, AND AMENDMENT

5.1 TERM

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated or superseded as specified herein.

5.2 TERMINATION OF AGREEMENT BY DHA

(a) The Director, DHA, or designee, may terminate this agreement upon written notice, for cause, if the Sole Provider is found not to be in compliance with the provisions set forth in TOM, Chapter 18, Section 4, 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.

(b) In addition, the Director, DHA, or designee, may terminated this agreement without cause by giving the Sole Provider written notice not less than 45 calendar days prior to the effective date of such termination.

5.3 TERMINATION OF AGREEMENT BY THE SOLE PROVIDER

The Sole Provider may terminate this agreement by giving the Director, DHA, or designee, written notice not less than 45 calendar days prior to the effective date of such termination. Effective the date of termination, the Sole Provider will cease being a TRICARE-authorized provider of Demonstration services. Subsequent to termination, a Sole Provider may be reinstated as a TRICARE-authorized provider of Demonstration services only by entering into a new Participation Agreement.

5.4 AMENDMENT BY DHA

(a) The Director, DHA, or designee, may amend the terms of this Participation Agreement by giving 120 calendar 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 TOM, Chapter 18, Section 4 and 32 CRF 199. When changes or modifications to this agreement result from changes to the 32 CFR 199 through rulemaking procedures, the Director, DHA, or designee, is not required to give 120 calendar days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective.

(b) A Sole Provider who does not accept the proposed amendment(s), including any amendment resulting from changes to TOM, Chapter 18, Section 4 and 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the Sole Provider notice of intent to terminate its participation is not given at least 30 calendar days prior to the effective date of the proposed amendment(s), the proposed amendment(s) shall be incorporated into this agreement for services furnished by the Sole Provider between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 6

EFFECTIVE DATE

6.1 DATE SIGNED

This Participation Agreement is effective on the date signed by the Director, DHA, or designee.

DHA:

_____

By: Signed Name and Title

Sole Provider:

_____

By: Signed Name and Title

Executed on _____, 20____

_____
(TIN)

_____
(NPI)

ALL PRACTITIONERS
STATEMENT OF RELEASE AND UNDERSTANDING

I hereby certify that the information provided in this application is true and accurate and reflects my current level of training, experience, and demonstrated competence to practice with the clinical privileges I have requested. I understand that I have the burden and legal responsibility of providing true and adequate information to demonstrate my professional competence, character, moral ethics, and other qualifications. I further understand that any significant misstatement or omission on this application may constitute cause for denial of participation or dismissal from Health Net Federal Services (HNFS) or be subject to applicable state or federal penalties for perjury.

I agree to authorize HNFS, its representatives or agents to conduct a criminal history records check and to consult with and inspect all documents from individuals and organizations having information bearing on my qualifications, including present and past professional liability insurance carrier(s), including information concerning any restriction on my clinical privilege coverage and any information concerning those cases which have been settled, lost, received judgment or are pending. I further consent to the release of information concerning any professional misconduct proceeding, and any malpractice actions involving me in any state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions, and to the fullest extent permitted by law, release practitioners of such information from any and all liability.

I further authorize the copy of my signature on this document, as part of the application, to be as binding as the original. I agree that HNFS, its representatives and individuals or entities providing information to HNFS in good faith shall not be liable for any act or occasion related to the evaluation or verification contained in this document, which is part of the application. I further agree to notify HNFS in a timely manner of any change to the information requested in this application. Information requested in this application that is not publicly available will be treated as confidential by HNFS.

I declare under penalty of perjury that my license(s) is/are in good standing. I agree to notify HNFS within ten (10) days of any change to the status of my license, or any investigation into my licensure.

Applicant Name (please print): _____

Please go to second page of document for signature line.

Applicant Social Security Number*: _____
*(*A social security number is required to conduct a background check)*

Applicant Date of Birth*: _____
*(*Date of birth is required to conduct a background check)*

Attached you will find a document that lists the limitation on the number of years that a state can report criminal and/or Bankruptcy cases under state law. Using the attached document, please list all states in which you have lived during the reporting period. Please include the name of the last city in which you resided in within the state. If you have been licensed in any state in which you have not lived, please indicate that state as well (Please PRINT legibly)

State	Reporting period
CA	10 years
KY	no limit
ME	10 years
MD	10 years
MA	10 years
MT	14 years
NV	10 years
NH	10 years
NM	14 years
NY	14 years
TX	10 years
WA	10 years
All Other States	7 years

I have lived in the following cities and states:
(Example: If you lived in CA 12 years ago, you do NOT need to list CA. If you have EVER lived in KY, please list KY). You need only include one city per state.

City	State

Current Address:

Street _____

City _____ State_____ Zip_____

Applicant Signature: _____

Gender: ____ Male ____ Female

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 _____

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 _____