NON-NETWORK TRICARE PROVIDER FILE GROUP APPLICATION

Please complete this application if adding or updating a non-network Group Practice, Clinic, Professional associations, corporations, partnerships, etc to TRICARE. Failure to provide complete and accurate information will negatively impact claims payment.

Instructions for completing the application:

- Complete the group application demographic information page.
- Using the Group Member Listing, list all practitioners with their name, SSN, NPI, Specialty, and the date they joined the group.
- For each practitioner, complete the appropriate TRICARE certification requirements page. Please note, TRICARE Requirements are specific to the provider type* and complete information is required to ensure each practitioner meets TRICARE requirements. Failure to provide complete information will negatively impact claims payment.

**Physicians and dentists can be added to our provider files using licensure information only. We will only require an application if licensure is unavailable online or if the information provided conflicts with online resources.*

To certify Certified Marriage and Family Therapists and Pastoral Counselors, TRICARE requires a completed individual application and a signed Participation Agreement for each practitioner.

Please submit the completed application package to:

Fax: 888-279-3540

or

Mail to:
TRICARE North Region
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756

Note: TRICARE non-network provider data management will not reply to successful updates to our provider file. You may view and update your provider information by registering on myTRICARE.com. You may file claims after 30 days of submitting your application unless notified that we require additional information. Inquiring about the status of your application within this timeframe may delay processing.

NON-NETWORK TRICARE PROVIDER FILE
GROUP APPLICATION DEMOGRAPHIC INFORMATION

Please complete one demographic page and group member listing for **each** location.

Group name: _____

Federal Tax ID Number: _____

Group NPI #: _____

Physical Location (Street Address):

_____

_____

_____

Telephone #: _____

Fax #: _____

Mailing or Billing Address (If different):

_____

_____

_____

Telephone #: _____

Billing Fax #: _____

Date legal entity established: _____

Will each practitioner sign their own claim form _____ 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.

GROUP MEMBER LISTING

Please complete one demographic page and group member listing for **each** location.

PRACTITIONER NAME (LAST, FIRST, MIDDLE)	SSN NUMBER	NPI NUMBER	PRIMARY SPECIALTY	DATE JOINED GROUP
1. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ISSUE DATE: _____ EXPIRATION DATE: _____				
2. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ISSUE DATE: _____ EXPIRATION DATE: _____				
3. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ISSUE DATE: _____ EXPIRATION DATE: _____				
4. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ISSUE DATE: _____ EXPIRATION DATE: _____				
5. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ISSUE DATE: _____ EXPIRATION DATE: _____				
6. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ISSUE DATE: _____ EXPIRATION DATE: _____				
7. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ISSUE DATE: _____ EXPIRATION DATE: _____				
8. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ISSUE DATE: _____ EXPIRATION DATE: _____				
9. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ISSUE DATE: _____ EXPIRATION DATE: _____				
10. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ISSUE DATE: _____ EXPIRATION DATE: _____				

Registered Nurse (RN)/Licensed Practical Nurse (LPN)/Nurse Practitioner (NP) Requirements

To verify each **Registered Nurse (RN)/Licensed Practical Nurse (LPN)/Nurse Practitioner (NP)** in your group meets TRICARE requirements**,** please provide the following information for **each** practitioner. 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.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: (Select applicable license)

___ Registered Nurse (RN)
___ Licensed Practical Nurse (LPN)
___ Nurse Practitioner (NP)

License Number: _____

Original License Issue Date: _____ Expiration Date: _____

or

Licensure: If in a state that does **not** offer licensure as a Nurse Practitioner, please provide the following:

Registered Nurse License Number: _____

Original License Issue Date: _____ Expiration Date: _____

Certification: *is certified by a national nurse practitioner board*

_____ Yes _____ No

Certification Number: _____

Original Issue Date: _____ Expiration Date: _____

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: _____

Physician Assistant (PA) Requirements

To verify each **Physician Assistant (PA)** in your group meets the TRICARE requirements, please provide the following information for **each** practitioner. 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.

Practitioner Name: _____ Practitioner NPI: _____

Licensure:

License Number: _____

Original License Issue Date: _____ Expiration Date: _____

Certification: *is certified by the National Commission on Certification of the Physician Assistant to assist primary care physician by a national nurse practitioner board*

_____ Yes _____ No

Certification Number: _____

Original Issue Date: _____ Expiration Date: _____

Or if not nationally certified: has satisfactorily completed a program for preparing physician assistants that:

a. Was at least one academic year in length; and
b. Consisted of supervised clinical practice and at least four months (in the aggregate) of classroom instruction directed toward preparing students to deliver healthcare; and
c. Was accredited by the American Medical Association's committee on Allied Health Education and Accreditation.

_____ Yes _____ No

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: _____

Physical/Speech/Occupational Therapist/Audiologist Requirements

To verify each **Physical/Speech/Occupational Therapist/Audiologist** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. 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.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: (Select applicable license)
___ Physical Therapist
___ Speech Pathologist
___ Occupational Therapist
___ Audiologist
___ Hippotherapy Physical Therapist/Occupational (A copy of your certificate from the American Hippotherapy Certification Board is required)

License Number: _____

Original License Issue Date: _____ Expiration Date: _____

If in a state that does **not** offer licensure as a Speech Pathologist or Audiologist, please provide the following:

Certification: *has a certificate of membership in the American Speech, Language and Hearing Association*

Certification Number: _____

Original Issue Date: _____ Expiration Date: _____

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: _____

Certified Registered Nurse Anesthetist (CRNA) Requirements

To verify each **Certified Registered Nurse Anesthetist (CRNA)** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. 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.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *If you practice in a state that **does** offer licensure as a Certified Registered Nurse Anesthetist, please provide the following:*

CRNA License Number: _____ State: _____

Original License Issue Date: _____ Expiration Date: _____

Or

Licensure: *If you practice in a state that does **not** offer licensure as a Certified Registered Nurse Anesthetist, please provide the following:*

Registered Nurse License Number: _____ State: _____

Original License Issue Date: _____ Expiration Date: _____

Certification: *is certified by the Council on Certification of Nurse Anesthetists*

_____ Yes _____ No

Certification Number: _____

Original Issue Date: _____ Expiration Date: _____

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: _____

Anesthesiologist Assistant (AA) Requirements

To verify each **Anesthesiologist Assistant (AA)** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. 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.

Practitioner Name: _____ Practitioner NPI: _____

Education: *Is a graduate of a **Master's** level anesthesiologist assistant educational program that:*

-is established under auspices of an accredited medical school
-is accredited by the Commission on Accreditation of Allied Health Educational Programs (successor organization to the Committee on Allied Health Education and Accreditation, or its successor organization)
-includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

Date Graduated: _____ Degree Earned: _____

Name of University: _____

Licensure: *If practicing in a state that **does** offer licensure as an Anesthesiologist Assistant please provide the following:*

Anesthesiologist Assistant License Number: _____

Original License Issue Date: _____ Expiration Date: _____

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: _____

Nutritionist Requirements

To verify each **Nutritionist** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. 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.

Practitioner Name: _____ Practitioner NPI: _____

Licensure:

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Education: *Has received at least a **bachelor's** degree from an accredited U.S. college or university*

Date Graduated: _____ Degree Earned: _____

Name of University: _____

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: _____

Registered Dietician Requirements

To verify each **Registered Dietician** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. 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.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *If required in your state*

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Education: *Has received at least a **bachelor's** degree from an accredited U.S. college or university*

Date Graduated: _____ Degree Earned: _____

Name of University: _____

Accreditation: *Has been accredited by the Academy of Nutrition and Dietetics' commission for a Didactic Program in Dietetics*

_____ Yes _____ No

Date of accreditation: _____

Exam: *Has passed the Registration Examination for Dietitians as specified by state licensure*

Date passed: _____

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: _____

Certified Nurse Midwife (CNM) Requirements

To verify each **Certified Nurse Midwife (CNM)** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. 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.

TRICARE certified Nurse Midwives must be licensed as a Registered Nurse in addition to certification by the American College of Nurse Midwives or American Midwifery Certification Board. State Nurse Midwife licenses are not accepted by TRICARE. A lay midwife who is neither a Certified Nurse Midwife (CNM) nor a Registered Nurse is not an authorized provider, and TRICARE will not reimburse a lay midwife for services regardless of whether the services rendered may otherwise be covered.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *must be licensed as a Registered Nurse*

License Number: _____

Original License Issue Date: _____ Expiration Date: _____

Certification: *is certified by the American College of Nurse Midwives or American Midwifery Certification Board*

_____ Yes _____ No Certification Number: _____

Original Issue Date: _____ Expiration Date: _____

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: _____

Clinical Psychologist Requirements

To verify each **Clinical Psychologist** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. 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.

Practitioner Name: _____ Practitioner NPI: _____

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: _____

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: _____

☐ **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: _____

Certified Psychiatric Nurse Specialist Requirements

To verify each **Certified Psychiatric Nurse Specialist** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. 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.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *Is a licensed, registered nurse*

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Education: *Has at least a **master's** degree in nursing with a specialization in psychiatric and mental health nursing*

Date Graduated: _____ Degree Earned: _____

Name of University: _____

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

☐ **Clinical Experience:** *Has two years post-Master's experience degree practice in the field of psychiatric and mental health nursing, including an average of eight hours of direct patient contact per week*

_____ Yes _____ No Date Experience Requirements Met: _____

☐ **ANCC Certification:** If you do not meet the clinical experience requirements listed, you meet TRICARE requirements if you are certified by the American Nurses Association through the American Nurses Credentialing Center (ANCC). The following ANCC certifications meet this requirement. Please select the applicable certification:

___ Adult or Psychiatric and Mental Health Clinical Nurse Specialist (CNS)
___ Child/ Adolescent- Psychiatric and Mental Health Clinical Nurse Specialist (CNS)
___ Adult Psychiatric Mental Health Nurse Practitioner (NP)
___ Family Psychiatric Mental Health Nurse Practitioner (NP)
___ Psychiatric and Mental Health Nurse Practitioner (NP)

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: _____

Clinical Social Worker (CSW) Requirements

To verify each **Clinical Social Worker** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. 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.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *licensed or certified as a CSW by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of CSWs, is certified by a national professional organization offering certification of CSWs*

License/Certification Number: _____

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

Education: *Has at least a **master's** degree in social work from a graduate school of social work accredited by the **Council on Social Work Education***

Date Graduated: _____ Degree Earned: _____

Name of University: _____

Clinical Experience: *Has completed a minimum of two years or three thousand hours of post-Master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting*

_____ Yes _____ No Date Experience Requirements Met: _____

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: _____

Supervised Mental Health Counselor (SMHC) Requirements

To verify each **Supervised Mental Health Counselor (SMHC)** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. In the TRICARE program, a SMHC requires oversight by a physician. 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.

Practitioner Name: _____ Practitioner NPI: _____

Licensure:

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Education:

Date Graduated: _____ Degree Earned: _____

Name of University: _____

Clinical Experience:

Has had two years of post-master's experience which includes 3,000 hours of clinical work and 100 hours of face-to-face supervision. _____ Yes _____ No

Date Experience Requirements Met: _____

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: _____

TRICARE Certified Mental Health Counselor Requirements

To verify each **TRICARE Certified Mental Health Counselor (TCMHC)** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. In the TRICARE program, A TCMHC does not require referral and oversight by a physician. 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.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *licensed for independent practice in mental health counseling by the jurisdiction where practicing*

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Clinical Experience: *has completed a minimum of two years of post-master's degree supervised mental health counseling practice that includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision. This supervision must be provided by mental health counselors, psychiatrists, clinical psychologists, certified clinical social workers, TCMHCs, or certified psychiatric nurse specialists who are licensed for independent practice in the jurisdiction where practicing and must be practicing within the scope of their licenses. Supervision must be conducted in a manner that is consistent with the guidelines regarding knowledge, skills and practice standards for supervision of the American Mental Health Counselors Association (AMHCA).*

_____ Yes _____ No Date Experience Requirements Met: _____

Please complete one of the Education and Exam sections below to ensure you meet TRICARE criteria:

Education: *has a master's or higher-level degree from a mental health counseling program of education and training accredited for* ***Mental Health Counseling or Clinical Mental Health Counseling*** *by the* ***Council for Accreditation of Counseling and Related Educational Programs (CACREP)*** *or the* ***Council for Higher Education Accreditation (CHEA)***

Date Graduated: _____

Degree Earned:

_____

Name of University: _____

_____

Exam: *Has passed the* ***National Clinical Mental Health Counselor Examination (NCMHCE)***

Date passed: _____

OR

Education: *has a master's or higher-level degree from a mental health counseling program of education and training accredited for* ***Mental Health Counseling or Clinical Mental Health Counseling*** *by the* ***Council for Accreditation of Counseling and Related Educational Programs (CACREP)***

Date Graduated: _____

Degree Earned:

_____

Name of University: _____

_____

Exam: *has passed the* ***National Counselor Examination (NCE)*** *or the* ***National Certified Counselors (NCC) examination.***

Date passed: _____

Note: *If the practitioner does not meet TRICARE Requirements to be a TCMHC, they may still qualify to be a Supervised Mental Health Counselor. Please complete the Supervised Mental Health Counselor requirements section.*

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 _____

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 _____