



**TRICARE
CLINICAL PSYCHOLOGIST
PROVIDER APPLICATION**

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.

TRICARE Non-Network Individual Clinical Psychologist Application

First Name: _____ MI: _____ Last Name: _____

Gen: _____ Title: _____

Social Security #: _____ NPI#: _____

Physical Address (Street Address):

Billing or Mailing Address (If Different):

Telephone #: _____

Billing Telephone #: _____

Fax #: _____

Billing Fax #: _____

** If you practice at multiple locations, please attach a list of additional office locations.

Do you maintain a solo practice? ____ Yes ____ No

If yes, Tax ID # of solo practice: _____

NPI#: _____

Date you began using this Tax ID #: _____

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

If yes, practice name: _____

Practice Tax ID #: _____

NPI#: _____

Effective date of the group's Tax ID number or EIN (Date legal entity established):

Date you began practicing with this group number: _____

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.

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. 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: _____

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: _____

TRICARE North Region Provider Data Management
Fax 1-888-279-3540
P.O. Box 870156 Surfside Beach, SC 29587-9756
www.myTRICARE.com by PGBA

Revised: 3/31/2016

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 _____