Print Form

TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29021-7039
Fax 803-462-3986

Toll-Free: 1-800-403-3950
www.myTRICARE.com by PGBA

Nurse/Anesthesiologist Assistant
Provider Application Package

TRICARE®
NURSE / ANESTHESIOLOGIST ASSISTANT PROVIDER APPLICATION

Please submit the completed application package to:

Fax:
803-462-3986

or

Mail to:
TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29021-7039

Authorization as a TRICARE provider does not include a network or contractual agreement with Humana Government Business. To become a TRICARE-contracted Network Provider for the South Region, please visit www.humana-military.com to inquire about joining the network.

Indicate the name and phone number of the person to contact if additional information is needed.

NAME: CREDENTIALING DEPARTMENT PHONE: 352-799-0046

EMAIL: CREDENTIALING@ACCESSHEALTHCARELLC.NET

Revised 11/4/14

Humana. Government Business

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TRICARE
NURSE / ANESTHESIOLOGIST ASSISTANT APPLICATION

NAME: _____

SOCIAL SECURITY NUMBER: _____ NPI#: _____

Do you maintain a solo practice? ☐ YES ☒ NO

IF YOU ARE SOLO INCORPORATED, PLEASE GIVE EIN NUMBER: _____

Are you employed by the U.S. Government? ☐ YES ☒ NO

OFFICE LOCATION (Street Address):

_____

_____

_____

Office Tele. No: (____) ____-_____ ext. _____

BILLING ADDRESS (If different):

PO BOX 919469

ORLANDO, FL 32891-9469

Billing Tele. No: (727) 823-2188 ext. _____

I will be signing my own claim forms: ☐ YES ☒ NO

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TRICARE NURSE APPLICATION

Please attach a copy of either your Registered Nurse license or your Licensed Practical Nurse license.

RN or LPN License Number: _____

Original License Date: ___/___/___ Current License Dates: From ___/___/___ To ___/___/___

In order to become TRICARE certified as any of the following Advanced Practice Nurses, you must also be licensed as a Registered Nurse. (Attach copy of current RN license.)

NURSE-MIDWIFE LICENSE AND CERTIFICATION INFORMATION:

License Number: _____ Certification Number: _____

Original License Date: ___/___/___ Current License Dates: From ___/___/___ To ___/___/___

NURSE PRACTITIONER LICENSE INFORMATION:

License Number: _____ Certification Number: _____

Original License Date: ___/___/___ Current License Dates: From ___/___/___ To ___/___/___

NURSE ANESTHETISTS:

ATTACH A PHOTOCOPY OF THE CARD ISSUED TO YOU by either the Council on Certification of Nurse Anesthetists or by the Council on Recertification of Nurse Anesthetists.

License Number: _____ Certification Number: _____

Original License Date: ___/___/___ Current License Dates: From ___/___/___ To ___/___/___

Name of Preceptor(s) (Supervising Physician) for practice:

_____

I understand that continued privileges are contingent on continued certification by the Council on Certification on Nurse Anesthetists.

_____ _____
Signature Date

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PSYCHIATRIC NURSE SPECIALIST

☐ I am a licensed registered nurse and I have at least a master's degree in nursing with a specialization in psychiatric and mental health nursing.
(ATTACH A COPY)

NAME OF SCHOOL: _____

DEGREE: _____ DISCIPLINE: _____

YEAR GRADUATED: _____

ATTACH A COPY OF RN LICENSE AS WELL AS PSYCHIATRIC AND MENTAL HEALTH NURSING ASSOCIATION ACCREDITATION.

☐ I have had at least two (2) years of post-master's degree practice in the field of psychiatric and mental health nursing including an average of eight (8) hours of direct patient contact per week.

Date experience requirement was met: ___/___/_____

OR

☐ I am certified by the American Nurses Association through the American Nurses Credentialing Center (ANCC), the professional body that meets the requirement for a CPNS to be listed in a TRICARE-recognized, professionally sanctioned listing of clinical specialists in psychiatric mental health nursing.

The following ANCC certifications meet this requirement:

- 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)

ANESTHESIOLOGIST ASSISTANTS

Anesthesiologist Assistants: ATTACH A COPY OF MASTER'S level of Anesthesiologist Degree from an educational program accredited by the Commission on Accreditation of Allied Health Education Programs.

1. Name of Preceptor(s) (Supervising Physician) for practice:

_____

2. Highest degree level: _____

   Identify Institution: _____

PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

STATE OF FLORIDA _____ COUNTY OF Hernando _____

Know all persons by these presents:

That I, _____ have made, constituted and appointed and by these

presents do make, constitute and appoint _____ (Please attach a list of any other authorized representatives) 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 Defense Health Agency (DHA). 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 OF Hernando _____ STATE OF FLORIDA _____

(SEAL) MY COMMISSION EXPIRES ____/____/____

Per Defense Health Agency (DHA) guidelines, we may accept, in lieu of a provider's actual signature on a TRICARE claim form, a facsimile signature or signature of a representative if the FI has on file a notarized authorization from the provider for use of a facsimile signature or a notarized authorization of power of attorney for another person to sign on his or her behalf.

The authorized representative may sign using the provider's name followed by the representative's initials or using the representative's own signature followed by "POA" (Power of Attorney), or similar indication of the type of authorization granted by the provider.

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PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

STATE OF FLORIDA _____ COUNTY OF Hernando _____

_____ being first duly sworn, deposes and says:
I hereby authorize the Contractor for TRICARE to accept my facsimile or stamp signature shown below:

_____

(Facsimile, stamp or computer-generated signature as it will appear on the claim form, type or print for electronic claims)

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.

_____

(Provider Signature)

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 20____.

_____
NOTARY PUBLIC IN AND FOR

COUNTY OF Hernando _____ STATE OF FLORIDA _____

(SEAL)

MY COMMISION EXPIRES _____/_____/_____

Per Defense Health Agency (DHA) guidelines, we may accept in lieu of a provider's actual signature on a TRICARE claim form, a facsimile signature. The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim is computer-generated.

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PRACTITIONER AUTHORIZATION FOR REASSIGNMENT OF BENEFITS TO CLINIC

TRICARE
PGBA, LLC

It is agreed that Access Healthcare Physicians, LLC
(Name of Clinic, Group or Professional Association)

will bill for and receive any charges or fees for the services of

_____
(Name of Practitioner)

_____
(Office Address)

_____

_____

_____ _____
Signature: Authorized Individual for Clinic Signature of Practitioner

451444883
_____ _____
Employer Identification Number Social Security Number

1245529742
_____ _____
NPI # for Employer Identification Number NPI # for Social Security Number

_____ _____
Date Date

Date Individual joined group practice: ___/___/_____

Please return to the address indicated at the top of this form.