Provider Information Form
Fax Cover Sheet

Fax to: Health Net Federal Services, LLC **Fax number: 1-844-224-0381**

Fill out the information below and use this page as a fax cover sheet for your Provider Information Form (PIF). We offer a fillable PDF version of this form at **www.tricare-west.com** > *Provider* > *Forms*.

Note: PIFs received without this fax cover sheet as the first page of your fax **will not** be processed.

Do not fax the "Dear Applicant" page of the form.

If you are faxing more than one PIF, you **must** include a fax cover sheet with each PIF.

Tax Identification Number
Type I National Provider Identifier (NPI)
Social Security Number -
CAQH ID (if applicable)

Dear Provider Applicant:

Thank you for your interest in participating in the Health Net Federal Services, LLC (HNFS) TRICARE Provider Network. HNFS utilizes the CAQH® Universal Credentialing DataSource® for the application and credentialing process. CAQH is a not-for-profit alliance of the nation's leading health plans, including HNFS. CAQH has developed a free, secure, online database for the collection of provider credentialing data where providers submit one standard application to a single database. All authorized health plans can access the information at any time.

Please complete and return the attached Provider Information Form (PIF) so we may add you to HNFS' roster of CAQH providers. If you do not already have one, we will alert CAQH to assign you one. Once we receive the completed PIF, **you will have up to thirty (30) days to complete your CAQH online application**; failure to do so will result in the discontinuation of the credentialing process with HNFS until you resubmit a new PIF. The credentialing process takes, on average 60–90 days to complete from the date of a completed application. You can check your credentialing status **online** at **www.tricare-west.com** > *Provider* > *Public Tools* > *Check Credentialing Status*.

HNFS policies require the following additional requisites for individual provider applicants to ensure we maintain quality of care standards for patients. Please be aware these are minimum standards. Failure to meet minimum standards may render an applicant ineligible for participation in the network. Network providers must be recredentialed every three years to maintain network status.

Note: Employees/contractors of contracted corporate service providers do not need to be credentialed.

Thank you for your interest in the TRICARE program. We look forward to partnering with you in providing health care services to our active duty service members, retirees and their families.

Health Net Federal Services
Credentialing Department

Steps for submission for new providers:

1. Have an existing network participation agreement on file, or attach a new HNFS agreement.
2. Complete and sign the PIF and Credential Attestation, Authorization and Release.
3. Return the PIF and all relevant materials to the address provided at the footer of your Provider Agreement cover letter.
4. If you do not already have a CAQH provider ID, we will alert CAQH to assign you one. CAQH will contact you via email or mail with instructions on how to set up your CAQH profile.
5. Once you receive notification from CAQH that you have been added to the HNFS roster, log in to the CAQH website at **www.caqh.org** to complete the CAQH application and ensure you authorize HNFS to access your information.
6. Ensure all CAQH information is complete and current, **including an image of Professional Liability Insurance.**
7. When the credentialing process is complete, we will send you written notification of the results. If you are approved for TRICARE network participation, we will send a fully executed copy of your participation agreement.

HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

Provider Information Form (PIF)

This form should be completed electronically or legibly printed in blue or black ink. All fields are required, unless otherwise noted.

Identifying Information *(Must match CAQH application)*

Last Name	First Name	MI	Title/Degree

Are you currently an active duty service member or an employee (including part-time or intermittent) appointed in the civil service of the United States government? ☐ Yes ☐ No

DOB	☐ Male ☐ Female	Individual Medicare ID Number

SSN (No dashes)	Individual NPI (Type I) (No dashes)	CAQH ID (If applicable)

Are you a solo practitioner? ☐ Yes ☐ No

Primary Directory Specialty Taxonomy Code _____	Secondary Directory Specialty (If applicable) Taxonomy Code _____	Third Directory Specialty (If applicable) Taxonomy Code _____

Are you participating as a primary care manager (PCM), and/or specialist (Spec), or as a hospital-based specialist?
☐ PCM ☐ Spec ☐ Hospital-based specialist

Are you accepting new patients? ☐ Yes ☐ No	Email Address

Practice Information *(Must match CAQH application)*

Practice Name _____

HNFS limits the number of locations listed for individual practitioners in its online Network Provider Directory to five (5). This limit does not apply to applied behavior analysis practitioners.

Primary Office Physical Address 1 ☒ **Display in provider directory**

Location Name _____ Address _____ City _____ State ____ ZIP _____
Phone _____ Fax _____ Location TIN _____ Location NPI _____

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Location Name _____ Address _____ City _____ State ____ ZIP _____
Phone _____ Fax _____ Location TIN _____ Location NPI _____

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Location Name _____ Address _____ City _____ State ____ ZIP _____
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Primary Office Physical Address 4 ☐ **Display in provider directory**

Location Name _____ Address _____ City _____ State ____ ZIP _____
Phone _____ Fax _____ Location TIN _____ Location NPI _____

Primary Office Physical Address 5 ☐ **Display in provider directory**

Location Name _____ Address _____ City _____ State ____ ZIP _____
Phone _____ Fax _____ Location TIN _____ Location NPI _____

Practice/Office Manager Name	Practice/Office Manager Phone		
Primary Billing Address	City	State	ZIP
TIN/EIN	NPI (Type II)	Billing Phone	Billing Fax

Do you deliver video-based telemedicine services? ☐ Yes ☐ No
If yes, you must review pages 5 and 6, and sign the Telemedicine Providers Attestation on page 6.

Do you currently file medical claims electronically? ☐ Yes ☐ No

Does your office meet all state and federal handicap access requirements? ☐ Yes ☐ No

Credentialing Point of Contact Information

Point of Contact Name	Email Address	Hours Available

Mailing Address	☐ Check if mailing address is same as primary office address	City	State	ZIP

Phone	Fax

Medicare

Lack of Medicare participation may restrict your eligibility to accept patients enrolled in government plans.

In order to participate in TRICARE, you must have a signed enrollment agreement with Medicare OR participate with Medicare on a claim-by-claim basis.

☐ **Yes** (I have a signed CMS 460 Agreement with Medicare or will participate with Medicare on a claim-by-claim basis.)	☐ **No**	☐ **Does not apply** (pediatricians, obstetricians, BCBAs, BCBA-D, BCa BAs, LPCs, MFTs and MHCs only)

Mental health providers, including psychiatric nurses, Board Certified Behavior Analysts® (BCBAs), Board Certified Assistant Behavior Analysts® (BCaBAs), BCBA-doctorals (BCBA-Ds), licensed applied behavior analysis (ABA) providers, Autism Corporate Services Providers (ACSPs), and opioid treatment providers must also complete their designated section below.

Mental Health Providers

HNFS requires practitioners to meet specific criteria for the following specialty areas. If you meet the requirements and wish to receive referrals for these specialties, check the appropriate box(es) and sign below to attest you meet the minimum criteria.

SPECIALTY	REQUIREMENTS
☐ **Adolescents**	• Demonstration of adequate and relevant academic coursework or clinical training in adolescent treatment. • For non-MDs, at least 1500 hours supervised experience treating adolescents and families. • In general, at least 30 percent of current practice involves the treatment of adolescents and their families.
☐ **Children**	• Demonstration of adequate and relevant academic coursework or clinical training in the treatment of children. • For non-MDs, at least 1500 hours supervised experience treating children and families. In general, at least 30 percent of current practice involves the treatment of children and their families.
☐ **Psychological Testing**	• Licensure as a psychologist. • Completion of doctorate level courses in test construction, statistics and measurement theories from a regionally accredited institution. • At least 1500 hours of supervised experience administering, scoring and interpreting psychological tests.
☐ **Psychiatrist, Child**	• Proof of Board Certification in child psychiatry or completion of a 2-year fellowship in child psychiatry approved by the American Council on Graduate Medical Education.

I hereby attest I meet the above requirements for all selected specialties.

Signature: _____ Date: _____

Please attest that you agree to abide by the following TRICARE regulations related to the delivery of telemedicine (TRICARE Policy Manual Chapter 7, Section 22.1).

- The use of interactive telecommunications systems is used to provide diagnostic and treatment services that are medically or psychologically necessary and appropriate.
- Any applicable referral and/or preauthorization requirements that apply for services under the TRICARE Program also apply when such services are delivered via telemedicine.
- (Prescribers only) All prescriptions for pharmaceuticals conform to TRICARE regulation(s) and state law(s) at both the originating site and the distant site. Prescription(s) for pharmaceutical(s) are medically appropriate and prescribed by a licensed clinician who is directly involved in the patient's current telemedicine episode of care.

The following requirements, criteria, and limitations are applicable to the provisions of medically or psychologically necessary care delivered via telemedicine.

1. Technical Requirements

Videoconferencing Platforms

Video conferencing platforms used for telemedicine services must have the appropriate verification, confidentiality, and security parameters necessary to be properly utilized for this purpose and must meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. Video-chat applications (e.g., Skype, Facetime) may not meet such requirements and should not be used unless appropriate measures are taken to ensure the application meets these requirements and that appropriate business associates agreements (if necessary) are in place to utilize such applications for telemedicine.

Connectivity

Telemedicine services provided through personal computers or mobile devices that use internet-based videoconferencing software programs must provide such services at a bandwidth and with sufficient resolutions to ensure the quality of the image and/or audio received is sufficient for the type of telemedicine services being delivered. Telemedicine services shall not be provided if this functional requirement is not met.

Privacy and Security

The following guidelines shall be followed to ensure the privacy and security of telemedicine services:

- Providers of telemedicine services shall ensure audio and video transmissions used are secured using point-to-point encryption that meets recognized standards.
- Providers of telemedicine services shall not utilize videoconference software that allows multiple concurrent sessions to be opened by a single user. While only one session may be open at a time, a provider may include more than two sites/patients as participants in that session with the consent of all participants (e.g., group psychotherapy).
- Protected Health Information (PHI) and other confidential data shall only be backed up to or stored on secure data storage locations that have been approved for this purpose. Cloud services unable to achieve compliance shall not be used for PHI or confidential data.

2. Provider Responsibilities

Providers rendering telemedicine services must follow telemedicine-specific regulatory, licensing, credentialing and privileging, malpractice and insurance laws and rules for their profession in both the jurisdiction (site) in which they are practicing as well as the jurisdiction (site) where the patient is receiving care, and shall ensure compliance as required by appropriate regulatory and accrediting agencies.

Providers rendering telemedicine services must follow professional discipline and national practice guidelines when practicing via telemedicine, and any modifications to applicable clinical practice guidelines for the telemedicine setting shall ensure that clinical requirements specific to the discipline are maintained. In addition, arrangements for handling emergency situations should be determined at the outset of treatment to ensure consistency with established local procedures. In particular, for mental health services, this should include processes for hospitalization or civil commitment within the jurisdiction where the patient is located if necessary.

Providers rendering telemedicine services must implement means for verification of provider and patient identity. For telemedicine services where the originating site is an authorized institutional provider, the verification of both professional and patient identity may occur at the host facility. For telemedicine services where the originating site does not have an immediately available health professional (e.g., the patient's home), the telemedicine provider shall provide the patient (or legal representative) with the provider's qualifications, licensure information, and, when applicable, registration number (e.g., National Provider Identification (NPI)). The patient shall provide two-factor authentication.

Providers must conform to TRICARE regulation(s) and states law(s) regarding the issuance of prescriptions for pharmaceuticals at both the originating site and the distant site. Prescription(s) for pharmaceutical(s) must be medically appropriate and prescribed by a licensed clinician who is directly involved in the patient's current telemedicine episode of care.

Continued on next page

Telemedicine Providers (continued)

The provider and patient location must be documented in the medical record as required for the appropriate payment of services. Documentation will include elements such as city/town, state, and ZIP code.

Providers must ensure that transmission and storage of data associated with asynchronous telemedicine services is conducted over a secure network and is compliant with HIPAA requirements.

Providers must establish an alternate plan for communicating with the patient (e.g., telephone) in the event of a technological breakdown/failure. This must be developed at the outset of treatment. In order for the telemedicine services to resume, all technological requirements of this policy must be restored, as telemedicine cannot be performed by telephone services alone.

HIPAA privacy and security requirements for the use and disclosure of PHI must apply to all telemedicine services.

As a condition of payment for synchronous telemedicine services, both the patient and healthcare provider must be present on the connection and participating.

☒ **I hereby attest that I abide by the above TRICARE requirements related to the delivery of telemedicine services.**

☐ Please indicate that I provide telemedicine in the provider directory.

☐ Please do not profile me as a telemedicine provider in the provider directory.

Provider Name: _____

Signature: _____

Psychiatric Nurses Only

1. **Does your state license have a designation in a psychiatric specialty?** ☐ Yes ☐ No
   If not, you must have an American Nurses Credentialing Center (ANCC) certificate.
2. **Are you certified by the ANCC?** ☐ Yes ☐ No
   If yes, the certification must be in one of the following areas:
   ☐ Nurse practitioner (NP), psychiatric (mental health NP) ☐ Specialty certifications (psychiatric, mental health nursing)

ANCC Certificate Number: _____ Expiration Date: _____

Opioid Treatment Provider

☐ Holds an MD, DO, PA, or ARNP license.

☐ Possesses a DATA 2000 waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA), allowing prescription of Suboxone for opioid addiction.

☐ Holds a specific DEA number for buprenorphine prescriptions for opioid addiction therapy.

DEA Number: _____ Expiration Date: _____

☐ Prescribes Buprenorphine/Suboxone

☐ Prescribes Naltrexone/Vivitrol

Important Information—Criminal History Review

As part of the Managed Care Support Contract for the TRICARE program in the T2017 West Region, HNFS is required to perform Criminal History Reviews of certain physicians and non-physician network providers. Contractors may search federal, state and county records in performing criminal history checks and may subcontract for these services.

Criminal History Reviews are performed on physicians with anomalies in their licensure history (four or more active and/or expired licenses) or who have been disciplined. Contractors also shall perform Criminal History Reviews on all non-physician providers who practice independently, and who are not supervised by a physician.

HNFS has chosen to subcontract for these services. Please note, a credit history is not being performed; however, as our reviews are considered investigative, they fall under the requirements of the Fair Credit Reporting Act. Therefore, this information has been provided as part of the Fair Credit Reporting Act.

A Summary of Your Rights Under the Fair Credit Reporting Act can be found online at: **https://www.ftc.gov/enforcement/rules/rulemaking-regulatory-reform-proceedings/fair-credit-reporting-act.**

Important Information—Investigative Consumer Report Disclosure

In connection with your employment or application for employment (including contract for services), an investigative consumer report and consumer reports, which may contain public record information, may be requested. These reports may include the following types of information: names and dates of previous employers, reason for termination of employment, work experience, accidents, academic history, professional credentials, drug/alcohol use, information relating to your character, general reputation, personal characteristics, mode of living, educational background or any other information about you which may reflect upon your potential for employment gathered from any individual, organization, entity, agency or other source, which may have knowledge concerning any such items of information. Such reports may contain public record information concerning your driving record, workers' compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies that maintain such records. You have the right to receive, upon a written request made within 60 days, a complete and accurate disclosure of the nature and scope of the investigation requested. You have the right to make a request to AbsoluteHire, upon proper identification, for the nature and substance of all information in its files on you at the time of your request, including the sources of information and the recipients of any reports on you that AbsoluteHire has previously furnished within the two-year period preceding your request. AbsoluteHire may be contacted by mail at 101 Creekside Ridge Ct., 2nd Floor, Riverside, CA 95678 or by phone at 1-800-943-2589.

Credentials Attestation, Authorization and Release

I acknowledge and agree that Health Net Federal Services, LLC (HNFS) has a valid interest and legal requirement to obtain and verify information concerning my professional competence, therefore:

1. I authorize HNFS and/or any entity with which it may contract for verification services to consult with hospital administrators, physicians, malpractice carriers and other persons or entities to obtain and verify information concerning my professional competence, character, moral and ethical qualifications. I release HNFS and its employees, managers, agents and consulting committees form any and all liability for their acts performed in good faith and without malice in obtaining, verifying and evaluating such information.

2. I consent to and authorize the release by any person or entity to HNFS of all information and documents that may be relevant to an evaluation of my professional competence, character, morality and ethical qualifications, including any information or material relating to any disciplinary or criminal action, professional competence, suspension or curtailment of medical or surgical privileges (including malpractice claims and/or coverage). I hereby release any such person or entity providing such information from any and all liability for doing so. If I have contracted with a medical group, Individual Physician Association or similar entity as a participating provider with HNFS or such other health plans, they also may receive the credentialing information or quality assurance data relating to me.

3. I understand that I have the burden and legal responsibility of providing adequate information to HNFS to demonstrate my professional competence, character, moral ethics and other qualifications.

4. I attest to the fact the information submitted by me in this application is true, correct and complete to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from, this application may constitute cause for denial of participation or cause for summary dismissal from the HNFS Provider Network, or be subject to applicable state or federal penalties for perjury.

5. If any material changes occur affecting my professional status, I agree to notify HNFS within five days, as per Section 2.16 of the Professional Provider Agreement.

6. I have attached my Professional Liability Insurance (PLI) with this form, or I have posted a current copy of my PLI on CAQH, which expires:

Date of Professional Liability Insurance Expiration

Note: Application will be returned if there is no current copy of PLI on CAQH.

Provider Name (Type or use block print)

Provider Signature

DocuSigned by:
selva
7EE185A4F2C94D5...

Date

Note: Must be signed and dated within 30 days of submittal.

Print Form

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Health Net Federal Services
Credentialing Department

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TRICARE®

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Identifying Information *(Must match CAQH application)*

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DOB	☐ Male ☐ Female	Individual Medicare ID Number

SSN (No dashes)	Individual NPI (Type I) (No dashes)	CAQH ID (If applicable)

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Practice/Office Manager Name	Practice/Office Manager Phone		
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TIN/EIN	NPI (Type II)	Billing Phone	Billing Fax

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Continued on next page

Telemedicine Providers (continued)

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HIPAA privacy and security requirements for the use and disclosure of PHI must apply to all telemedicine services.

As a condition of payment for synchronous telemedicine services, both the patient and healthcare provider must be present on the connection and participating.

☒ **I hereby attest that I abide by the above TRICARE requirements related to the delivery of telemedicine services.**

☐ Please indicate that I provide telemedicine in the provider directory.

☐ Please do not profile me as a telemedicine provider in the provider directory.

Provider Name: _____

Signature: _____

Psychiatric Nurses Only

1. **Does your state license have a designation in a psychiatric specialty?** ☐ Yes ☐ No
   If not, you must have an American Nurses Credentialing Center (ANCC) certificate.
2. **Are you certified by the ANCC?** ☐ Yes ☐ No
   If yes, the certification must be in one of the following areas:
   ☐ Nurse practitioner (NP), psychiatric (mental health NP) ☐ Specialty certifications (psychiatric, mental health nursing)

ANCC Certificate Number: _____ Expiration Date: _____

Opioid Treatment Provider

☐ Holds an MD, DO, PA, or ARNP license.

☐ Possesses a DATA 2000 waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA), allowing prescription of Suboxone for opioid addiction.

☐ Holds a specific DEA number for buprenorphine prescriptions for opioid addiction therapy.

DEA Number: _____ Expiration Date: _____

☐ Prescribes Buprenorphine/Suboxone

☐ Prescribes Naltrexone/Vivitrol

Important Information—Criminal History Review

As part of the Managed Care Support Contract for the TRICARE program in the T2017 West Region, HNFS is required to perform Criminal History Reviews of certain physicians and non-physician network providers. Contractors may search federal, state and county records in performing criminal history checks and may subcontract for these services.

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HNFS has chosen to subcontract for these services. Please note, a credit history is not being performed; however, as our reviews are considered investigative, they fall under the requirements of the Fair Credit Reporting Act. Therefore, this information has been provided as part of the Fair Credit Reporting Act.

A Summary of Your Rights Under the Fair Credit Reporting Act can be found online at: **https://www.ftc.gov/enforcement/rules/rulemaking-regulatory-reform-proceedings/fair-credit-reporting-act.**

Important Information—Investigative Consumer Report Disclosure

In connection with your employment or application for employment (including contract for services), an investigative consumer report and consumer reports, which may contain public record information, may be requested. These reports may include the following types of information: names and dates of previous employers, reason for termination of employment, work experience, accidents, academic history, professional credentials, drug/alcohol use, information relating to your character, general reputation, personal characteristics, mode of living, educational background or any other information about you which may reflect upon your potential for employment gathered from any individual, organization, entity, agency or other source, which may have knowledge concerning any such items of information. Such reports may contain public record information concerning your driving record, workers' compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies that maintain such records. You have the right to receive, upon a written request made within 60 days, a complete and accurate disclosure of the nature and scope of the investigation requested. You have the right to make a request to AbsoluteHire, upon proper identification, for the nature and substance of all information in its files on you at the time of your request, including the sources of information and the recipients of any reports on you that AbsoluteHire has previously furnished within the two-year period preceding your request. AbsoluteHire may be contacted by mail at 101 Creekside Ridge Ct., 2nd Floor, Riverside, CA 95678 or by phone at 1-800-943-2589.

Credentials Attestation, Authorization and Release

I acknowledge and agree that Health Net Federal Services, LLC (HNFS) has a valid interest and legal requirement to obtain and verify information concerning my professional competence, therefore:

1. I authorize HNFS and/or any entity with which it may contract for verification services to consult with hospital administrators, physicians, malpractice carriers and other persons or entities to obtain and verify information concerning my professional competence, character, moral and ethical qualifications. I release HNFS and its employees, managers, agents and consulting committees form any and all liability for their acts performed in good faith and without malice in obtaining, verifying and evaluating such information.

2. I consent to and authorize the release by any person or entity to HNFS of all information and documents that may be relevant to an evaluation of my professional competence, character, morality and ethical qualifications, including any information or material relating to any disciplinary or criminal action, professional competence, suspension or curtailment of medical or surgical privileges (including malpractice claims and/or coverage). I hereby release any such person or entity providing such information from any and all liability for doing so. If I have contracted with a medical group, Individual Physician Association or similar entity as a participating provider with HNFS or such other health plans, they also may receive the credentialing information or quality assurance data relating to me.

3. I understand that I have the burden and legal responsibility of providing adequate information to HNFS to demonstrate my professional competence, character, moral ethics and other qualifications.

4. I attest to the fact the information submitted by me in this application is true, correct and complete to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from, this application may constitute cause for denial of participation or cause for summary dismissal from the HNFS Provider Network, or be subject to applicable state or federal penalties for perjury.

5. If any material changes occur affecting my professional status, I agree to notify HNFS within five days, as per Section 2.16 of the Professional Provider Agreement.

6. I have attached my Professional Liability Insurance (PLI) with this form, or I have posted a current copy of my PLI on CAQH, which expires:

Date of Professional Liability Insurance Expiration

Note: Application will be returned if there is no current copy of PLI on CAQH.

Provider Name (Type or use block print)

Provider Signature

DocuSigned by:
selva
7EE185A4F2C94D5...

Date

Note: Must be signed and dated within 30 days of submittal.

Print Form

Provider Information Form
Fax Cover Sheet

Fax to: Health Net Federal Services, LLC **Fax number: 1-844-224-0381**

Fill out the information below and use this page as a fax cover sheet for your Provider Information Form (PIF). We offer a fillable PDF version of this form at **www.tricare-west.com** > *Provider* > *Forms*.

Note: PIFs received without this fax cover sheet as the first page of your fax **will not** be processed.

Do not fax the "Dear Applicant" page of the form.

If you are faxing more than one PIF, you **must** include a fax cover sheet with each PIF.

Tax Identification Number
Type I National Provider Identifier (NPI)
Social Security Number -
CAQH ID (if applicable)

Dear Provider Applicant:

Thank you for your interest in participating in the Health Net Federal Services, LLC (HNFS) TRICARE Provider Network. HNFS utilizes the CAQH® Universal Credentialing DataSource® for the application and credentialing process. CAQH is a not-for-profit alliance of the nation's leading health plans, including HNFS. CAQH has developed a free, secure, online database for the collection of provider credentialing data where providers submit one standard application to a single database. All authorized health plans can access the information at any time.

Please complete and return the attached Provider Information Form (PIF) so we may add you to HNFS' roster of CAQH providers. If you do not already have one, we will alert CAQH to assign you one. Once we receive the completed PIF, **you will have up to thirty (30) days to complete your CAQH online application**; failure to do so will result in the discontinuation of the credentialing process with HNFS until you resubmit a new PIF. The credentialing process takes, on average 60–90 days to complete from the date of a completed application. You can check your credentialing status **online** at **www.tricare-west.com** > *Provider* > *Public Tools* > *Check Credentialing Status*.

HNFS policies require the following additional requisites for individual provider applicants to ensure we maintain quality of care standards for patients. Please be aware these are minimum standards. Failure to meet minimum standards may render an applicant ineligible for participation in the network. Network providers must be recredentialed every three years to maintain network status.

Note: Employees/contractors of contracted corporate service providers do not need to be credentialed.

Thank you for your interest in the TRICARE program. We look forward to partnering with you in providing health care services to our active duty service members, retirees and their families.

Health Net Federal Services
Credentialing Department

Steps for submission for new providers:

1. Have an existing network participation agreement on file, or attach a new HNFS agreement.
2. Complete and sign the PIF and Credential Attestation, Authorization and Release.
3. Return the PIF and all relevant materials to the address provided at the footer of your Provider Agreement cover letter.
4. If you do not already have a CAQH provider ID, we will alert CAQH to assign you one. CAQH will contact you via email or mail with instructions on how to set up your CAQH profile.
5. Once you receive notification from CAQH that you have been added to the HNFS roster, log in to the CAQH website at **www.caqh.org** to complete the CAQH application and ensure you authorize HNFS to access your information.
6. Ensure all CAQH information is complete and current, **including an image of Professional Liability Insurance.**
7. When the credentialing process is complete, we will send you written notification of the results. If you are approved for TRICARE network participation, we will send a fully executed copy of your participation agreement.

HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

Provider Information Form (PIF)

This form should be completed electronically or legibly printed in blue or black ink. All fields are required, unless otherwise noted.

Identifying Information *(Must match CAQH application)*

Last Name	First Name	MI	Title/Degree

Are you currently an active duty service member or an employee (including part-time or intermittent) appointed in the civil service of the United States government? ☐ Yes ☐ No

DOB	☐ Male ☐ Female	Individual Medicare ID Number

SSN (No dashes)	Individual NPI (Type I) (No dashes)	CAQH ID (If applicable)

Are you a solo practitioner? ☐ Yes ☐ No

Primary Directory Specialty Taxonomy Code _____	Secondary Directory Specialty (If applicable) Taxonomy Code _____	Third Directory Specialty (If applicable) Taxonomy Code _____

Are you participating as a primary care manager (PCM), and/or specialist (Spec), or as a hospital-based specialist?
☐ PCM ☐ Spec ☐ Hospital-based specialist

Are you accepting new patients? ☐ Yes ☐ No	Email Address

Practice Information *(Must match CAQH application)*

Practice Name _____

HNFS limits the number of locations listed for individual practitioners in its online Network Provider Directory to five (5). This limit does not apply to applied behavior analysis practitioners.

Primary Office Physical Address 1 ☒ **Display in provider directory**

Location Name _____ Address _____ City _____ State ____ ZIP _____
Phone _____ Fax _____ Location TIN _____ Location NPI _____

Primary Office Physical Address 2 ☐ **Display in provider directory**

Location Name _____ Address _____ City _____ State ____ ZIP _____
Phone _____ Fax _____ Location TIN _____ Location NPI _____

Primary Office Physical Address 3 ☐ **Display in provider directory**

Location Name _____ Address _____ City _____ State ____ ZIP _____
Phone _____ Fax _____ Location TIN _____ Location NPI _____

Primary Office Physical Address 4 ☐ **Display in provider directory**

Location Name _____ Address _____ City _____ State ____ ZIP _____
Phone _____ Fax _____ Location TIN _____ Location NPI _____

Primary Office Physical Address 5 ☐ **Display in provider directory**

Location Name _____ Address _____ City _____ State ____ ZIP _____
Phone _____ Fax _____ Location TIN _____ Location NPI _____

Practice/Office Manager Name	Practice/Office Manager Phone		
Primary Billing Address	City	State	ZIP
TIN/EIN	NPI (Type II)	Billing Phone	Billing Fax

Do you deliver video-based telemedicine services? ☐ Yes ☐ No
If yes, you must review pages 5 and 6, and sign the Telemedicine Providers Attestation on page 6.

Do you currently file medical claims electronically? ☐ Yes ☐ No

Does your office meet all state and federal handicap access requirements? ☐ Yes ☐ No

Credentialing Point of Contact Information

Point of Contact Name	Email Address	Hours Available

Mailing Address	☐ Check if mailing address is same as primary office address	City	State	ZIP

Phone	Fax

Medicare

Lack of Medicare participation may restrict your eligibility to accept patients enrolled in government plans.

In order to participate in TRICARE, you must have a signed enrollment agreement with Medicare OR participate with Medicare on a claim-by-claim basis.

☐ **Yes** (I have a signed CMS 460 Agreement with Medicare or will participate with Medicare on a claim-by-claim basis.)	☐ **No**	☐ **Does not apply** (pediatricians, obstetricians, BCBAs, BCBA-D, BCa BAs, LPCs, MFTs and MHCs only)

Mental health providers, including psychiatric nurses, Board Certified Behavior Analysts® (BCBAs), Board Certified Assistant Behavior Analysts® (BCaBAs), BCBA-doctorals (BCBA-Ds), licensed applied behavior analysis (ABA) providers, Autism Corporate Services Providers (ACSPs), and opioid treatment providers must also complete their designated section below.

Mental Health Providers

HNFS requires practitioners to meet specific criteria for the following specialty areas. If you meet the requirements and wish to receive referrals for these specialties, check the appropriate box(es) and sign below to attest you meet the minimum criteria.

SPECIALTY	REQUIREMENTS
☐ **Adolescents**	• Demonstration of adequate and relevant academic coursework or clinical training in adolescent treatment. • For non-MDs, at least 1500 hours supervised experience treating adolescents and families. • In general, at least 30 percent of current practice involves the treatment of adolescents and their families.
☐ **Children**	• Demonstration of adequate and relevant academic coursework or clinical training in the treatment of children. • For non-MDs, at least 1500 hours supervised experience treating children and families. In general, at least 30 percent of current practice involves the treatment of children and their families.
☐ **Psychological Testing**	• Licensure as a psychologist. • Completion of doctorate level courses in test construction, statistics and measurement theories from a regionally accredited institution. • At least 1500 hours of supervised experience administering, scoring and interpreting psychological tests.
☐ **Psychiatrist, Child**	• Proof of Board Certification in child psychiatry or completion of a 2-year fellowship in child psychiatry approved by the American Council on Graduate Medical Education.

I hereby attest I meet the above requirements for all selected specialties.

Signature: _____ Date: _____

Please attest that you agree to abide by the following TRICARE regulations related to the delivery of telemedicine (TRICARE Policy Manual Chapter 7, Section 22.1).

- The use of interactive telecommunications systems is used to provide diagnostic and treatment services that are medically or psychologically necessary and appropriate.
- Any applicable referral and/or preauthorization requirements that apply for services under the TRICARE Program also apply when such services are delivered via telemedicine.
- (Prescribers only) All prescriptions for pharmaceuticals conform to TRICARE regulation(s) and state law(s) at both the originating site and the distant site. Prescription(s) for pharmaceutical(s) are medically appropriate and prescribed by a licensed clinician who is directly involved in the patient's current telemedicine episode of care.

The following requirements, criteria, and limitations are applicable to the provisions of medically or psychologically necessary care delivered via telemedicine.

1. Technical Requirements

Videoconferencing Platforms

Video conferencing platforms used for telemedicine services must have the appropriate verification, confidentiality, and security parameters necessary to be properly utilized for this purpose and must meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. Video-chat applications (e.g., Skype, Facetime) may not meet such requirements and should not be used unless appropriate measures are taken to ensure the application meets these requirements and that appropriate business associates agreements (if necessary) are in place to utilize such applications for telemedicine.

Connectivity

Telemedicine services provided through personal computers or mobile devices that use internet-based videoconferencing software programs must provide such services at a bandwidth and with sufficient resolutions to ensure the quality of the image and/or audio received is sufficient for the type of telemedicine services being delivered. Telemedicine services shall not be provided if this functional requirement is not met.

Privacy and Security

The following guidelines shall be followed to ensure the privacy and security of telemedicine services:

- Providers of telemedicine services shall ensure audio and video transmissions used are secured using point-to-point encryption that meets recognized standards.
- Providers of telemedicine services shall not utilize videoconference software that allows multiple concurrent sessions to be opened by a single user. While only one session may be open at a time, a provider may include more than two sites/patients as participants in that session with the consent of all participants (e.g., group psychotherapy).
- Protected Health Information (PHI) and other confidential data shall only be backed up to or stored on secure data storage locations that have been approved for this purpose. Cloud services unable to achieve compliance shall not be used for PHI or confidential data.

2. Provider Responsibilities

Providers rendering telemedicine services must follow telemedicine-specific regulatory, licensing, credentialing and privileging, malpractice and insurance laws and rules for their profession in both the jurisdiction (site) in which they are practicing as well as the jurisdiction (site) where the patient is receiving care, and shall ensure compliance as required by appropriate regulatory and accrediting agencies.

Providers rendering telemedicine services must follow professional discipline and national practice guidelines when practicing via telemedicine, and any modifications to applicable clinical practice guidelines for the telemedicine setting shall ensure that clinical requirements specific to the discipline are maintained. In addition, arrangements for handling emergency situations should be determined at the outset of treatment to ensure consistency with established local procedures. In particular, for mental health services, this should include processes for hospitalization or civil commitment within the jurisdiction where the patient is located if necessary.

Providers rendering telemedicine services must implement means for verification of provider and patient identity. For telemedicine services where the originating site is an authorized institutional provider, the verification of both professional and patient identity may occur at the host facility. For telemedicine services where the originating site does not have an immediately available health professional (e.g., the patient's home), the telemedicine provider shall provide the patient (or legal representative) with the provider's qualifications, licensure information, and, when applicable, registration number (e.g., National Provider Identification (NPI)). The patient shall provide two-factor authentication.

Providers must conform to TRICARE regulation(s) and states law(s) regarding the issuance of prescriptions for pharmaceuticals at both the originating site and the distant site. Prescription(s) for pharmaceutical(s) must be medically appropriate and prescribed by a licensed clinician who is directly involved in the patient's current telemedicine episode of care.

Continued on next page

Telemedicine Providers (continued)

The provider and patient location must be documented in the medical record as required for the appropriate payment of services. Documentation will include elements such as city/town, state, and ZIP code.

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☐ Holds an MD, DO, PA, or ARNP license.

☐ Possesses a DATA 2000 waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA), allowing prescription of Suboxone for opioid addiction.

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Note: Application will be returned if there is no current copy of PLI on CAQH.

Provider Name (Type or use block print)

Provider Signature

DocuSigned by:
selva
7EE185A4F2C94D5...

Date

Note: Must be signed and dated within 30 days of submittal.

Print Form