TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039
Fax 803-462-3986

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

Marriage and Family Therapist, Pastoral Counselor Provider Application Package

TRICARE®
MARRIAGE AND FAMILY THERAPIST
PASTORAL COUNSELOR
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 29020-7039

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

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TRICARE
PROVIDER FILE APPLICATION

NAME: ____

SOCIAL SECURITY NUMBER: ________________________ NPI#: _________________________

OFFICE LOCATION (Street Address): BILLING ADDRESS (If different):

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

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

If you file your taxes under a Federal Employer Identification Number because you are incorporated or belong to an incorporated group/professional association, you must also complete a GROUP APPLICATION FORM.

Are you joining an established group practice or institution? YES NO

If YES, Practice Name: ____

Tax ID Number: _________________________ NPI#: _________________________

You must complete the REASSIGNMENT OF BENEFITS FORM if the group will bill on your behalf.

Date you began filing with group number: ___/___/_____

I will be signing my own claim forms: YES NO

If NO, then the enclosed Facsimile Signature Authorization Form(s) must be completed.

Do you maintain a solo practice? YES NO

Date you began solo practice: ___/___/_____

Tax ID Number of solo practice: _________________________ NPI#: ________________________

I certify that I have met the following requirements to be reimbursed as a Marriage and Family Therapist.

I certify that I have met the following requirements to be reimbursed as a Pastoral Counselor.

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ATTACH A PHOTOCOPY OF YOUR LICENSE OR CERTIFICATION

License No.: ________________________

Original License Date: ___/___/_____ Issuing State: __________________________

Current License Effective Dates: From ___/___/_____ To ___/___/_____

NOTE: If your state does not offer licensure, you MUST be a member of the American Association for Marriage and Family Therapy. PLEASE ATTACH A PHOTOCOPY OF YOUR AAMFT CERTIFICATE.

CONFLICT OF INTEREST STATEMENT

Federal Law (5 U.S.C. 5536) prohibits medical personnel who are active duty members or civilian employees of the government from receiving additional government compensation above their normal pay and allowance for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. Claims for TRICARE benefits will be denied where either a uniformed member or civilian employee of the uniformed services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to himself, herself, or others with some potential for personal gain or the appearance of impropriety.

____ _________________________
Signature of Applicant Signature Date

I, the undersigned provider, in submitting this application for certification as an authorized provider under the TRICARE program, do affirm and attest that the information which I have provided in response to and support of this application is true and correct. I understand that any misrepresentation of my credentials which bear upon my qualification for authorized TRICARE provider status may be subject to the Administrative Remedies for Fraud, Abuse and Conflict of Interest as defined in Chapter 9 of the TRICARE Regulation, 32 CFR 199.9.

____ _________________________
Signature of Applicant Signature Date

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PHYSICIAN AUTHORIZATION FOR REASSIGNMENT OF BENEFITS TO CLINIC

TRICARE
PGBA, LLC

It is agreed that ____
(Name of Clinic, Group or Professional Association)

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

____
(Name of Provider)

____
(Office Address)

____

____

_________________________________ Signature: Authorized Individual for Clinic

__________________________________ Signature of Provider

_________________________________ Employer Identification Number

____________________ Social Security Number

____________________ 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.

SECTION C-A
MARRIAGE AND FAMILY THERAPIST

FAILURE TO COMPLETE ALL APPLICABLE PARTS OF THIS SECTION WILL RESULT IN DELAY AND OR DENIAL OF CERTIFICATION.

I have a master's degree from an accredited educational institution in an appropriate behavioral science field with a mental health discipline. (ATTACH COPY OF DEGREE and COLLEGE TRANSCRIPT)

SCHOOL NAME: ________________________________ MONTH/YEAR GRADUATED: _______

DEGREE: _____________________________ DISCIPLINE: _____________________________

IF YOU HAVE A MASTER'S OF EDUCATION, PLEASE ATTACH A COPY OF YOUR SCHOOL TRANSCRIPT. WITHOUT VERIFICATION OF COURSE OF STUDY, YOU MAY NOT QUALIFY FOR TRICARE CERTIFICATION.

I am licensed/certified in the state in which I practice. (ATTACH COPY)
You must obtain a state license or certificate to be eligible for TRICARE reimbursement if it is offered by your state, even if the state program is on a voluntary basis.

ORIGINAL LICENSE DATE: ___/___/_____

CURRENT LICENSE EFFECTIVE DATES: FROM ___/___/_____ TO ___/___/_____

IF THE STATE IN WHICH YOU PRACTICE DOES NOT OFFER LICENSING OR CERTIFICATION FOR MARRIAGE AND FAMILY COUNSELING, THEN YOU MUST CERTIFY THAT:

I am a full CLINICAL member of the American Association for Marriage and Family Therapy (AAMFT). ATTACH PROOF OF MEMBERSHIP or

I have attached proof that I meet the requirements to become a full CLINICAL member of the AAMFT.

I CERTIFY THAT I HAVE SUCCESSFULLY COMPLETED THE MINIMUM EXPERIENCE:

Two hundred (200) hours of approved supervision in the practice of marriage and family counseling or pastoral counseling, ordinarily to have been completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision occurred preferably with more than one supervisor and should include a continuous process of supervision with at least three cases, AND one thousand (1,000) hours of clinical experience in the practice of marriage and family counseling or pastoral counseling under approved supervision, involving at least 50 different cases; OR

One hundred-fifty (150) hours of approved supervision in the practice of psychotherapy, ordinarily to have been completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling or pastoral counseling, AND seven hundred-fifty (750) hours of clinical experience in the practice of psychotherapy under approved supervision, involving at least 20 cases.

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SECTION C-B
PASTORAL COUNSELOR

FAILURE TO COMPLETE ALL APPLICABLE PARTS OF THIS SECTION WILL RESULT IN DELAY AND OR DENIAL OF CERTIFICATION.

I have a master's degree from an accredited educational institution in an appropriate behavioral science field with a mental health discipline. (ATTACH COPY OF DEGREE and COLLEGE TRANSCRIPT)

SCHOOL NAME: ________________________________ MONTH/YEAR GRADUATED: _______

DEGREE: _____________________________ DISCIPLINE: _____________________________

IF YOU HAVE A MASTER'S OF EDUCATION, PLEASE ATTACH A COPY OF YOUR SCHOOL TRANSCRIPT. WITHOUT VERIFICATION OF COURSE OF STUDY, YOU MAY NOT QUALIFY FOR TRICARE CERTIFICATION.

I am licensed/certified in the state in which I practice. (ATTACH COPY)
You must obtain a state license or certificate to be eligible for TRICARE reimbursement if it is offered by your state, even if the state program is on a voluntary basis.

ORIGINAL LICENSE DATE: ___/___/_____

CURRENT LICENSE EFFECTIVE DATES: FROM ___/___/_____ TO ___/___/_____

IF THE STATE IN WHICH YOU PRACTICE DOES NOT OFFER LICENSING OR CERTIFICATION FOR PASTORAL COUNSELOR, THEN YOU MUST CERTIFY THAT:

I am a fellow or diplomate member in the American Association for Pastoral Counselors (AAPC).

I have attached proof that I meet the requirements to become a fellow or diplomate member in the AAPC.

I CERTIFY THAT I HAVE SUCCESSFULLY COMPLETED THE MINIMUM EXPERIENCE:

Two hundred (200) hours of approved supervision in the practice of marriage and family counseling or pastoral counseling, ordinarily to have been completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision occurred preferably with more than one supervisor and should include a continuous process of supervision with at least three cases, AND one thousand (1,000) hours of clinical experience in the practice of marriage and family counseling or pastoral counseling under approved supervision, involving at least 50 different cases; OR

One hundred-fifty (150) hours of approved supervision in the practice of psychotherapy, ordinarily to have been completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling or pastoral counseling, AND seven hundred-fifty (750) hours of clinical experience in the practice of psychotherapy under approved supervision, involving at least 20 cases.

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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 ____________________________________ (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 TRICARE Management Activity (TMA). 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 _________________________________ STATE OF ___________________________

(SEAL) MY COMMISSION EXPIRES ____/____/____

Per TRICARE Management Activity (TMA) 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 ___________________________ COUNTY OF __________________________________

_______________________________________ being first duly sworn, deposes and says:

I hereby authorize the Contractor for TRICARE in the state of _____________________________ to accept my facsimile or stamp signature shown below as my true 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 FACSIMILE OR STAMP SIGNATURE
(*Stamp, Print or Type*)

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

____
NOTARY PUBLIC IN AND FOR

COUNTY OF _________________________________ STATE OF ___________________________

(SEAL) MY COMMISION EXPIRES _______/_______/_______

Per TRICARE Management Activity (TMA) 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.

TRICARE PARTICIPATION AGREEMENT FOR
CERTIFIED MARRIAGE AND FAMILY THERAPISTS

____
(Name of Certified Marriage and Family Therapist)

____
(Office Address)

____

____

____
(Telephone)

____
(TRICARE Provider Billing Number)

ARTICLE 1
RECITALS

1.1 Identification of Parties

This Participation Agreement is between the United States of America through the Department of Defense, TRICARE Management Activity (hereinafter TMA), a field activity of the Office of the Secretary of Defense, the administering activity for the TRICARE Management Activity

(hereinafter TMA) and ____

doing business as ____,
(hereinafter designated certified marriage and family therapist(s).

1.2 Authority for Certified Marriage and Family Therapists as Authorized Providers

32 Code of Federal Regulations Part 199 provides for cost-sharing of services provided by certified marriage and family therapists under certain conditions.

1.3 Purpose of Participation Agreement

The purpose of this participation agreement is to:

(a) Establish the undersigned certified marriage and family therapist as an authorized provider of mental health services;

(b) Establish the terms and conditions that the undersigned certified marriage and family therapist must meet.

1.4 Billing Number

The certified marriage and family therapist's billing number for all mental health services rendered is the certified marriage and family therapist's social security number or employer's identification number (EIN). This billing number must be used until the provider is officially notified by TMA of a change. The certified marriage and family therapist's number is shown on the face sheet of this agreement. It is the only billing number that will be accepted by TMA claims processors after the effective date of this agreement for becoming an authorized certified marriage and family therapist.

ARTICLE 2
PERFORMANCE PROVISIONS

2.1 General Agreement

The certified marriage and family therapists agrees to render medically necessary and appropriate covered mental health services within the scope of his practice and licensure to eligible beneficiaries as required by this participation agreement and the 32 CFR 199.6. The terms and conditions of 32 CFR 199.6 applicable to the participation or treatment of beneficiaries by the certified marriage therapists are incorporated herein by reference.

2.2 Licensure and Certification Requirements

The certified marriage and family therapists certifies and attaches hereto documentation that:

(a) He/she is now licensed or certified to practice as a marriage and family therapists by the state in which practicing; or

(b) If practicing in a state which does not provide specific licensure or certification, the certified marriage and family therapist must be certified eligible for full clinical membership in the American Association for Marriage and Family Therapy; and

(c) He/she has a recognized graduate professional education with a minimum of an earned master's degree from an accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(d) He/she has the following experience:

(1) Either 200 hours of approved supervision in the practice of marriage and family counseling, ordinarily to be completed in a 2- to 3- year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

(2) 1000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases; or

(3) 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2 to 3 year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

(4) 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling under approved supervision, involving at least 20 cases.

2.3 The certified marriage and family therapist agrees that, having an exclusive election to participate as a certified marriage and family therapist, he or she will not be authorized in any other category of extra medical provider, either during or subsequent to the period this agreement is in effect.

ARTICLE 3
PAYMENT PROVISIONS

3.1 Determined Allowable Charge

The determined allowable charge is the maximum amount that can be authorized for services rendered by an authorized individual professional provider of care. The determined allowable charge is determined following the provisions set forth in 32 CFR 199.14.

3.2 Determined Allowable Charge as Payment in Full.

The certified marriage and family therapist agrees to accept the determined allowable charge as payment in full for services rendered to beneficiaries, except applicable deductible and cost-shares.

3.3 Hold Harmless

The certified marriage and family therapist agrees to hold eligible beneficiaries harmless for non-covered care (i.e., certified marriage and family therapist may not bill a beneficiary for non-covered care and may not balance bill the beneficiary for amounts above the determined allowable charge).

ARTICLE 4
TERM, TERMINATION AND AMENDMENT

4.1 Term

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated by either party.

4.2 Termination of Agreement by TMA

The Executive Director, TMA, or designee, may terminate this agreement upon written notice, for cause, if the certified marriage and family therapist is found not to be in compliance with the provisions set forth in 32 CFR 199.6, 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.

4.3 Termination of Agreement By the Certified Marriage and Family Therapist

The certified marriage and family therapist may terminate this agreement by giving the Executive Director, TMA, or designee, written notice of such intent to terminate at least 60 days in advance of the effective date of termination. Effective the date of termination, the certified marriage and family therapist will no longer be recognized as an authorized provider, and reinstatement shall be disallowed for any other category of extramedical individual provider. Subsequent to termination, the certified marriage and family therapist may only be reinstated as an authorized extramedical provider by entering into a new participation agreement as certified marriage and family therapist.

4.4 Amendment by TMA

(a) The Executive Director, TMA or designee, may amend the terms of this participation agreement by giving 120 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 32 CFR 199. When changes or modifications to this agreement result from changes to the 32 CFR 199 through rulemaking procedures, the Executive Director, TMA or designee, is not required to give 120 days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective.

(b) The certified marriage and family therapist, not wishing to accept the proposed amendment(s), including any amendment resulting from the changes to the 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the certified marriage and family therapist notice of intent to terminate its participation is not given at least 60 days *prior* to the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into this agreement for services furnished by the certified marriage and family therapist between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 5
EFFECTIVE DATE

5.1 Date Signed
This participation agreement is effective on the date signed by the Executive Director, TMA, or designee.

TMA	Certified Marriage and Family Therapist
______________________________	______________________________
By: Signed Name	By: Signed Name
______________________________	______________________________
Title	Title
______________________________	______________________________
By: Typed Name and Title	By: Typed Name and Title

Executed on ______________________, 20____

TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039
Fax 803-462-3986

TERMS AND CONDITIONS FOR ELECTRONIC FUNDS TRANSFER

By Signing below your company agrees to accept payment by PGBA, LLC (PGBA) through electronic funds transfer (EFT). Additionally, you acknowledge and agree that all payments shall be made in accordance with the information that you supply on the Electronic Funds Transfer Authorization Form and that PGBA shall be entitled to rely exclusively upon such information. This agreement applies to and amends all existing agreements with PGBA by incorporating the following terms and conditions for electronic payment. PGBA will initiate payment to you based on the following:

1. PBGA will transfer funds electronically to the financial institution and account number you register on the attached EFT/ERA Enrollment Form.

2. PGBA will make payments in accordance with and be governed by the National Automated Clearinghouse Association's Corporation Trade Payment Rules. Our process is governed by and in accordance with the laws, other than choice of law provision of any particular contract, of South Carolina, including Article 4A of the Uniform Commercial Code as enacted by South Carolina and amended from time to time.

3. The information you provide on the EFT/ERA Enrollment Form is very important. PGBA shall not be liable for any loss which may arise solely by reason of error, mistake, or fraud regarding this information. **You understand that you must communicate any change in this information to PGBA. This communication must be in the form of a new EFT ERA Enrollment Form faxed to this number:**

PGBA, LLC EFT
Fax: 803-462-3995

4. Payment is initiated within the normal terms of our agreement with you and/or applicable TRICARE procedures. Our EFT terms and conditions neither enlarge nor diminish the parties' respective rights and obligations within any applicable agreement. The payment due date is not affected. We will consider payment made when your financial institution has received or has control of the payment transaction. This will generally occur within three (3) calendar days following initiation by PGBA. If payment is initiated on a nonbanking day at PGBA's originating bank, the funds transfer will occur the following banking day. In all cases, "Banking Day" is defined as the day on which both trading partners' banks are available to transmit and receive these fund transfers.

5. With respect to the EFT reimbursement process, PGBA is responsible up to the point where your financial institution receives or has control of the transaction. Any loss of data at that point will be borne by you unless the loss is due solely to the negligence of PGBA or its originating bank.
You hereby represent that you are authorized to enter into this agreement, disburse funds, sign checks, and modify account information for the provider locations listed below.

NAME: ________________________________ SIGNATURE: ______________________________
(Print)

TITLE: ________________________________ DATE: ____________________

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Marriage and Family Therapist, Pastoral Counselor Provider Application Package

TRICARE ERA/EFT ENROLLMENT FORM

Transaction Type: **EFT (Electronic Funds Transfer)** **ERA (Electronic Remittance Advice)**

General Provider Information	
Provider's Name	
Address	
Phone	E-mail Address
Federal Tax ID	NPI

Electronic Remittance Advice (ERA) Information

I hereby authorize ______________________________ to receive
Billing Service/Clearinghouse/Trading Partner

Electronic Remittance Advices (ERA's) on my behalf. I understand that ERA's contain payment information concerning my processed TRICARE claims. I acknowledge that it is my responsibility to notify PGBA, LLC in writing if I wish to revoke this authorization.

EDIG Trading Partner ID/Submitter ID	

Electronic Funds Transfer (EFT) Information	
Bank Name	
Address	
Bank Contact Name	Phone
Bank Transit/Routing Number	Account Number
Type of Account:	Saving Checking

I hereby authorize PGBA, LLC to initiate credit entries and, if necessary, debit entries and adjust and credit entries in error. I also authorize the bank named above to credit and/or debit the same to this account.

Signature(s)	
Name/Title (*Please Print)*	Date
Signature (*I am authorized to endorse this enrollment on behalf of my company.)*	Phone

This authorization is to remain in full force and effect until PGBA, LLC has received faxed notification of its termination.

☐ Check to indicate all locations with a different physical address utilizing the Federal Tax Identification number identified on the previous page should receive Electronic Remittance Advice (ERA). If only certain locations should receive ERA's, list them below.

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

NAME: ____ PHONE: ____________________________

TRICARE Provider Number (with suffix)	National Provider Identifier (NPI #)	Business Name and Address

☐ Check to indicate payment for all locations with a different physical address are to be transmitted to the Banking Transit/Routing and Account number listed on the previous page. If only certain locations are to be included, list them below.

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

NAME: ______________________________ PHONE: ______________________

TRICARE Provider Number (with suffix)	National Provider Identifier (NPI #)	Business Name and Address