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

Toll-Free: 1-800-403-3950

# TRICARE PROVIDER FILE APPLICATION

NAME:____________________SOCIAL SECURITY NO: __________________________

If you are a solo incorporate, please give your EIN #:_____________________________

NPI#: _____________________________________

Office Location (Street Address): Billing Address (If different):

__________________________________ ____________________________________

__________________________________ ____________________________________

Office Phone No: (___)___-__________ Billing Phone No: (___)____-_____________

If you file your taxes under a Federal Employer Identification Number because you belong to an incorporated group/professional association, you must ALSO complete a GROUP APPLICATION and the enclosed REASSIGNMENT OF BENEFITS FORM.

Are you a member of an established group practice or institution? _____ YES _____ NO

If YES, Practice Name:______________________Tax ID No:______________________

Date you began filing with group number: _____/_____/_____NPI#_________________

Do you maintain a solo practice by yourself? _____ YES _____ NO

I will be signing my own claim forms: _____ YES _____ NO. If not, then the enclosed FACSIMILE SIGNATURE AUTHORIZATION FORM (S) MUST BE COMPLETED.

I certify that I have met the following requirements to be reimbursed as a (n):

_____ MENTAL HEALTH COUNSELOR

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

Toll-Free: 1-800-403-3950

ATTACH A PHOTOCOPY OF YOUR LICENSE OR CERTIFICATION

License No: _______________Issuing State: ______________NPI#_____________

Original License Date: ______________________________________

Current License Effective Dates: From____________________To__________________

CONFLICT OF INTEREST STATEMENT

"Federal Law (5 U.S.C. 5536) prohibits medical personnel who are active duty members or civilian employees of 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 one or more providers on a selective basis."

______________________________________ ___________________________
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, DoD 6010.8-R."

______________________________________ ___________________________
Signature of Applicant Signature Date

Please notify Provider Certification of any changes related to your provider file information (name, address, specialty, tax number, group affiliations, etc.).

TRICARE South Region Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039
Fax 803-462-3986
Toll-Free: 1-800-403-3950

## SECTION D

Failure to complete all applicable parts of this section will result in delay and or denial of certification.

Provider Name: _______________________________

_____ A) I have a master's degree in a mental health counseling or allied mental health field from a regionally accredited educational institution (Attach copy of degree and college transcript):

Name of School: _______________________________________________________

Degree:_________________Discipline:_____________Year Graduated: _____________

If you have a Master's of Education, please attach a copy of your school transcript. Without verification of course study, you may not qualify for TRICARE certification.

_____ B) I have had two (2) years post-master's experience including three thousand (3,000) hours of clinical work and have received the required one hundred (100) hours of face-to-face supervision.

Name and address of the individual or organization that provided the clinical experience and supervision for the two years_____________________________________________
_______________________________________________________________________
_______________________________________________________________________

_____ C) I am licensed in the state in which I practice. (Attach copy of license.)

Original License Date: ____________________________

Current License Effective Dates: From _____________ To _____________

If the state in which you practice does not offer licensing or certification for mental health counseling or psychotherapy, then you must certify that:

_____ I am certified by the National Board for Certified Counselors, Inc. (NBCC). ATTACH PROOF OF MEMBERSHIP.

_____ I am eligible for membership in the National Board for Certified Counselors, Inc. (NBCC). ATTACH PROOF OF ELIGIBILITY. (Membership information for the NBCC can be obtained by contacting them at 910-547-0607.)

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

Toll-Free: 1-800-403-3950

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. 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 facsimiles 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.

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

Toll-Free: 1-800-403-3950

PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

STATE OF ______________________________

COUNTY OF ____________________________

__________________________________________ being first duly sworn, deposes and says: I hereby authorize the TRICARE Management Activity to accept my facsimile or stamp signature shown below 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 full-payment 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

SUBSCRIBED AND SWORN TO BEFORE ME THIS_______DAY OF _______20_____

__________________________________________

NOTARY PUBLIC IN AND FOR

COUNTY OF________________________STATE OF ____________________________

(SEAL) MY COMMISSION EXPIRES _____/_____/_____

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

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

Toll-Free: 1-800-403-3950

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 letter.