

TRICARE Program
PGBA, LLC
Provider Management
P.O. Box 870156
Surfside Beach, SC 29587-9756
1-877-TRICARE (1-877-874-2273)
Fax 1-888-279-3540

Dear Non-Network Provider,

Enclosed, please find a certification package for marriage and family therapists and/or pastoral counselors along with a Participation Agreement for TRICARE authorized providers.

You will note that the requirements for TRICARE certification are somewhat more stringent than you have been accustomed to in the past. The reason for this is a Policy change initiated by TMA with an implementation date of June 1, 1994. This package includes the revised certification requirements outlined in the change which offers pastoral counselors the option to become authorized under TRICARE as certified marriage and family therapists, eliminating the requirement for physician referral and supervision of services.

It is our pleasure to be of service to you. Should you have any questions or concerns, please contact a representative at the address or toll-free number at the top of this letter.

Please be sure to sign the participation agreement under Article 5 before returning your provider packet.

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TRICARE PROVIDER FILE APPLICATION

Name: _____ Social Security Number: _____

Telephone Number: _____ Billing Telephone Number: _____

Office Location (Street Address): _____ Billing Address (If Different): _____

Home Address (Street Address): _____ Emergency Telephone Number

(_____) _____ - _____

If you are filing your taxes under a Federal Employer Identification number because you are incorporated or belong to an incorporated group/professional association, YOU MUST COMPLETE A GROUP APPLICATION FORM.

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

If YES, practice name: _____ PROVIDER Number: _____

YOU MUST COMPLETE THE REASSIGNMENT OF BENEFITS FROM IF THE GROUP WILL BILL ON YOUR BEHALF. Date you began filling with group number: ____/____/____

I will be signing my own claim forms YES NO. If NO, FACSIMILE SIGNATURE AUTHORIZATION FORM MUST BE COMPLETED.

Do you maintain a solo practice? Yes No

Date you began solo practice: ____/____/____

Tax ID number of solo practice: _____

ATTACH A PHOTOCOPY OF YOUR LICENSE OR CERTIFICATION.

License No: _____ Original License Date: ____/____/____

Issuing State: _____ Expiration License Date: ____/____/____

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.

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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 one or more providers on a selective basis."

Signature of Applicant

Signature Date

PHYSICIAN AUTHORIZATION FOR REASSIGNMENT OF BENEFITS TO CLINIC
TRICARE SERVICES

It is agreed that _____
(Name of Clinic, Group or Professional Assoc.)

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

(Name of Provider)

Authorized Signature for Clinic

Signature of Provider

Employer Identification Number

License Number

Date

Social Security Number

Specialty

Date

Please notify the Provider Data Management Department of any changes related to your provider file information (name, address, tax number, group affiliations, etc.). Include your Provider Number and the effective date of the change.



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SECTION C

MARRIAGE AND FAMILY THERAPIST/PASTORAL COUNSELOR

FAILURE TO COMPLETE ALL APPLICABLE PARTS OF THIS APPLICATION WILL RESULT IN DELAY AND/OR DENIAL OF CERTIFICATION. RESUMES ARE NOT AN ACCEPTABLE SUBSTITUTE.

(1) _____ I have a Masters Degree from a regionally accredited educational institution in an appropriate behavioral science field or mental health discipline.

(2) SCHOOL NAME AND ADDRESS _____ DEGREE: _____
_____ DISCIPLINE: _____
_____ DATE OF GRADUATION: _____

(3) I have ATTACHED a copy of my:
_____ Transcript of Master's Degree program (including name and address of institution)
AND
_____ Copy of current license and original license.

NOTE: FAILURE TO ATTACH THE ABOVE DOCUMENTS WILL RESULT IN DELAY AND/OR DENIAL OF 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.

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. (Membership information for the AAMFT can be obtained by calling the AAMFT at (202-452-0109).

(SECTION C continued on next page)



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I CERTIFY THAT I HAVE SUCCESSFULLY COMPLETED THE MINIMUM EXPERIENCE AS MARKED BELOW. Signed _____.

_____ Two hundred (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

_____ 1,000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases;

OR

_____ 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

_____ 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.

Dates of clinical experience: ____/____/____ to ____/____/____.

Supervisor: _____

****NOTE**** Supervisor's name **NOT signature** is required, even if your supervisor is deceased.

FAILURE TO COMPLETE THIS FORM WILL RESULT IN DELAY AND/OR DENIAL OF CERTIFICATION. RESUMES ARE NOT AN ACCEPTABLE SUBSTITUTE FOR THIS FORM.



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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 Fiscal Intermediary for TRICARE in the state of South Carolina 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 CHAMPUS/CHAMPVA 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.



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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. My signature by my said Attorney-In-Fact includes my agreement to abide by the full payment concept and remainder of the certification appearing on all TRICARE/CHAMPVA 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 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 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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TRICARE PARTICIPATION AGREEMENT FOR
CERTIFIED MARRIAGE AND FAMILY THERAPISTS

Name of Certified Marriage and Family Therapists

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

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(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.

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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: John Beckham, Manager
Provider Data Management

_____(Signature)
By: _____
Name and Title

Date Signed: _____

Executed on _____, 20____



ELECTRONIC FUNDS TRANSFER (EFT)

Complete and FAX/Mail to: TRICARE North EFT, PO Box 870154, Surfside Beach, SC 29587-9754 or FAX completed form to 1-888-536-2324. (For assistance contact our EDI Help desk at, 1-877-334-2524).

PART I – PROVIDER OR SUPPLIER INFORMATION

Tax Identification (EIN or SSN) _____
National Provider Identifier _____
Name _____
Business Physical Address _____
_____ State _____ Zip Code _____ City _____
Phone Number _____ Fax Number _____

PART II – BANKING INFORMATION

Bank name _____
Bank Address _____
City _____ State _____ Zip Code _____
Bank contact name: _____ Phone Number _____
Bank Transit Number/ Routing Number (nine digit) _____ Bank
Account Number _____
Type of Account (check one) Checking Account Saving Account

PART III – CONTACT PERSON

Name _____
Business Physical Address _____
_____ State _____ Zip Code _____ City _____
Phone Number _____ Fax Number _____ E-mail
Address _____

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 (person with signature authority) _____ Date _____

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