



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: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 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.

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

- |  |  |
|--|--|
| _____ CLINICAL PSYCHOLOGIST<br>(Complete Section A)                                    | _____ CLINICAL SOCIAL WORKER<br>(Complete Section B)           |
| _____ MARRIAGE/FAMILY THERAPIST<br>(Complete Section C<br>and Participation Agreement) | _____ MENTAL HEALTH COUNSELOR<br>(Complete Section D)          |
| _____ PSYCHIATRIC NURSE<br>SPECIALIST<br>(Complete Section E)                          | _____ PASTORAL COUNSELOR<br>(Complete Section C)               |
| _____ DENTAL<br>(Complete Section F)   | _____ PHYSICIAN<br>(Complete Section F)                        |
| _____ PHYSICIAN ASSISTANT<br>(Complete Section G)                                      | _____ CERTIFIED NURSE<br>ANESTHETISTS<br>(Complete Section H)  |
| _____ REGISTERED NURSE<br>(Complete Section I)   | _____ PHYSICAL THERAPIST<br>(Complete Section J)               |
| _____ LICENSED PRACTICAL NURSE<br>(Complete Section I)                                 | _____ AUDIOLOGIST (Complete Section<br>J)                      |
| _____ CERTIFIED NURSE MIDWIFE<br>(Complete Section I)                                  | _____ SPEECH THERAPIST<br>(Complete Section J)                 |
| _____ NURSE PRACTITIONER<br>(Complete Section I)                                       | _____ OCCUPATIONAL/RESP THER<br>(PFTH)<br>(Complete Section J) |





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**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.).



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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.)





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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 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.





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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 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.





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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 letter.

