Non-network TRICARE Provider File Group Application

*We expect providers to submit claims electronically. If it is necessary to submit a paper claim, the only acceptable forms are the approved **red and white** NUCC 1500 (02-12) form and the NUBC UB-04 (CMS - 1450) forms. These forms must include the instructions on the back page.*

Please submit the completed application package to:

Fax: 1-877-989-0066

or

Mail to:

TRICARE West

Provider Data Management

PO Box 202169

Florence, SC 29502-2169

*TriWest Healthcare Alliance offers payments and remittances by National Provider Identifier (NPI) number. **The NPI billed on the claim will determine where payment and remittance will be sent.** It is critical the information provided matches how your office will file claims. Inconsistent data will negatively impact claims payment.*

*If your business requires multiple mailing/payment addresses, please provide an NPI for each. **If you have more than one NPI, you must complete a separate application for each NPI number.***

Revised: 03/19/2025

Instructions for completing the application

Please complete this application to add or update a non-network group practice, clinic, professional association, corporation, partnership, etc. for TRICARE.

- Complete the Demographic Information page
- List all practitioners with their name, SSN, NPI, specialty, and the date they joined the group on the Group Member Listing page
- For each practitioner, complete the appropriate TRICARE certification requirements page. **Please note:** TRICARE requirements are specific to the provider type*. Complete information is required to ensure each practitioner meets TRICARE requirements. Failure to provide complete information will negatively impact claims payment.

**Physicians and dentists can be added to our provider files using licensure information only. We will only require an application if licensure is unavailable online or if the information provided conflicts with online resources.*

For Certified Marriage and Family Therapists, TRICARE requires a completed individual application and a signed Participation Agreement for each practitioner.

Non-network TRICARE Provider File
Group Application Demographic Information

Please complete one demographic page and group member listing for **each** location.

Group name: _____

Federal Tax ID Number: _____

Group NPI #: _____

Physical Location (Street Address):

_____

_____

_____

Billing Address for this NPI (If different):

_____

_____

_____

Telephone #: _____

Fax #: _____

Telephone #: _____

Billing Fax #: _____

Date legal entity established: _____
(mm/dd/yyyy)

Are any of the practitioners affiliated with your group also employed by the US Government?

_____ Yes _____ No

If yes, please provide the name and NPI of the practitioner

Name: _____

NPI: _____

Will each practitioner sign their own claim form ☐ Yes ☐ No*

*Signature Authorization forms are attached. If the practitioner will not sign their own claim forms, please complete the signature authorization forms and have them notarized for each practitioner. Without signature authorization forms on file, each claim will require a physical signature from the rendering provider. Claims without a signature will be returned without processing for payment.

Group Member Listing

Please complete one demographic page and group member listing for **each** location. Provider payments and remittances are issued at the NPI level; therefore, additional Electronic Funds Transfer (EFT) forms do **NOT** need to be submitted for each member.

PRACTITIONER NAME (LAST, FIRST, MIDDLE)	SSN NUMBER	NPI NUMBER	PRIMARY SPECIALTY	DATE JOINED GROUP
1.				
LICENSE NUMBER:	ISSUE DATE:	EXPIRATION DATE:		
2.				
LICENSE NUMBER:	ISSUE DATE:	EXPIRATION DATE:		
3.				
LICENSE NUMBER:	ISSUE DATE:	EXPIRATION DATE:		
4.				
LICENSE NUMBER:	ISSUE DATE:	EXPIRATION DATE:		
5.				
LICENSE NUMBER:	ISSUE DATE:	EXPIRATION DATE:		
6.				
LICENSE NUMBER:	ISSUE DATE:	EXPIRATION DATE:		
7.				
LICENSE NUMBER:	ISSUE DATE:	EXPIRATION DATE:		
8.				
LICENSE NUMBER:	ISSUE DATE:	EXPIRATION DATE:		
9.				
LICENSE NUMBER:	ISSUE DATE:	EXPIRATION DATE:		
10.				
LICENSE NUMBER:	ISSUE DATE:	EXPIRATION DATE:		

Revised: 03/19/2025

Registered Nurse (RN)/Licensed Practical Nurse (LPN)/Nurse Practitioner (NP) Requirements

To verify that each **Registered Nurse (RN)/Licensed Practical Nurse (LPN)/Nurse Practitioner (NP)** in your group meets TRICARE requirements**,** please provide the following information for **each** practitioner. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: (Select applicable license)

- ☐ Registered Nurse (RN)
- ☐ Licensed Practical Nurse (LPN)
- ☐ Nurse Practitioner (NP)

License Number: _____

Original License Issue Date: _____ Expiration Date: _____

or

Licensure: If in a state that does **not** offer licensure as a Nurse Practitioner, please provide the following:

Registered Nurse License Number: _____

Original License Issue Date: _____ Expiration Date: _____

Certification: *is certified by a national nurse practitioner board*

_____ Yes _____ No

Certification Number: _____

Original Issue Date: _____ (mm/dd/yyyy) Expiration Date: _____ (mm/dd/yyyy)

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

Revised: 03/19/2025

Physician Assistant (PA) Requirements

To verify each **Physician Assistant (PA)** in your group meets the TRICARE requirements, please provide the following information for **each** practitioner. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Practitioner Name: _____ Practitioner NPI: _____

Licensure:

License Number: _____

Original License Issue Date: _____ Expiration Date: _____

Certification: *is certified by the National Commission on Certification of the Physician Assistant to assist primary care physicians*

____ Yes ____ No

Certification Number: _____

Original Issue Date: _____ Expiration Date: _____
(mm/dd/yyyy) (mm/dd/yyyy)

Or if not nationally certified: has satisfactorily completed a program for preparing physician assistants that:

a. Was at least one academic year in length; and
b. Consisted of supervised clinical practice and at least four months (in the aggregate) of classroom instruction directed toward preparing students to deliver healthcare; and
c. Was accredited by the American Medical Association's committee on Allied Health Education and Accreditation.

_____ Yes _____ No Date completed: _____
(mm/yyyy)

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

Revised: 03/19/2025

Physical/Speech/Occupational Therapist/Audiologist Requirements

To verify each **Physical/Speech/Occupational Therapist/Audiologist** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: (Select applicable license)

- ☐ Physical Therapist
- ☐ Speech Pathologist
- ☐ Occupational Therapist
- ☐ Audiologist
- ☐ Hippotherapy Physical Therapist/Occupational (A copy of your certificate from the American Hippotherapy Certification Board is required)

License Number: _____

Original License Issue Date: _____ Expiration Date: _____

If in a state that does **not** offer licensure as a Speech Pathologist or Audiologist, please provide the following:

Certification: *has a certificate of membership in the American Speech, Language and Hearing Association or is certified by the American Board of Audiology*

Certification Number: _____

Original Issue Date: _____ Expiration Date: _____
(mm/dd/yyyy) (mm/dd/yyyy)

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

Certified Registered Nurse Anesthetist (CRNA) Requirements

To verify each **Certified Registered Nurse Anesthetist (CRNA)** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *If you practice in a state that **does** offer licensure as a Certified Registered Nurse Anesthetist, please provide the following:*

CRNA License Number: _____ State: _____

Original License Issue Date: _____ Expiration Date: _____

Or

Licensure: *If you practice in a state that does **not** offer licensure as a Certified Registered Nurse Anesthetist, please provide the following:*

Registered Nurse License Number: _____ State: _____

Original License Issue Date: _____ Expiration Date: _____

Certification: *is certified by the Council on Certification of Nurse Anesthetists*

_____ Yes _____ No

Certification Number: _____

Original Issue Date: _____ Expiration Date: _____
(mm/dd/yyyy) (mm/dd/yyyy)

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

Anesthesiologist Assistant (AA) Requirements

To verify each **Anesthesiologist Assistant (AA)** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Practitioner Name: _____ Practitioner NPI: _____

Education: *Is a graduate of a **Master's** level anesthesiologist assistant educational program that:*

-is established under auspices of an accredited medical school
-is accredited by the Commission on Accreditation of Allied Health Educational Programs (successor organization to the Committee on Allied Health Education and Accreditation, or its successor organization)
-includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

Date Graduated: _____ Degree Earned: _____
(mm/yyyy)

Name of University: _____

Licensure: *If practicing in a state that **does** offer licensure as an Anesthesiologist Assistant please provide the following:*

Anesthesiologist Assistant License Number: _____

Original License Issue Date: _____ Expiration Date: _____

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

Revised: 03/19/2025

Nutritionist Requirements

To verify each **Nutritionist** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Practitioner Name: _____ Practitioner NPI: _____

Licensure:

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Education: *Has received at least a **bachelor's** degree from an accredited U.S. college or university*

Date Graduated: _____ Degree Earned: _____
(mm/yyyy)

Name of University: _____

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

Registered Dietician Requirements

To verify each **Registered Dietician** in your group meets TRICARE requirements, please provide the following information for **each** practitioner PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *If required in your state*

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Education: *Has received at least a **bachelor's** degree from an accredited U.S. college or university*

Date Graduated: _____ Degree Earned: _____
(mm/yyyy)

Name of University: _____

Accreditation: *Has been accredited by the Academy of Nutrition and Dietetics' commission for a Didactic Program in Dietetics*

_____ Yes _____ No Date of accreditation: _____
(mm/dd/yyyy)

Exam: *Has passed the Registration Examination for Dietitians as specified by state licensure*

Date passed: _____
(mm/dd/yyyy)

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

Certified Nurse Midwife (CNM) Requirements

To verify each **Certified Nurse Midwife (CNM)** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

TRICARE certified Nurse Midwives must be licensed as a Registered Nurse in addition to certification by the American Midwifery Certification Board. A lay midwife who is neither a Certified Nurse Midwife (CNM) nor a Registered Nurse is not an authorized provider, and TRICARE will not reimburse a lay midwife for services regardless of whether the services rendered may otherwise be covered.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *must be licensed as a Certified Nurse Midwife*

License Number: _____

Original License Issue Date: _____ Expiration Date: _____

****Attach a copy of State license***

Licensure: *must be licensed as a Registered Nurse*

License Number: _____

Original License Issue Date: _____ Expiration Date: _____

****Attach a copy of State license***

Certification: *is certified by the American College of Nurse Midwives or American Midwifery Certification Board*

_____ Yes _____ No Certification Number: _____

Original Issue Date: _____ Expiration Date: _____
(mm/dd/yyyy) (mm/dd/yyyy)

Attach a copy of certification

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

Clinical Psychologist Requirements

To verify each **Clinical Psychologist** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *licensed or certified by the state for the independent practice of psychology*

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Education: *Has a **doctoral** degree in psychology from a regionally accredited university*

Date Graduated: _____ Degree Earned: _____
(mm/yyyy)

Name of University: _____

In addition to **Licensure** and **Education**, please complete one of the following:

☐ **Clinical Experience:** *Has completed two years supervised clinical experience in psychological health services of which at least one year is post-doctoral and one year (may be the post-doctoral year) is in an organized psychological health service training program*

_____ Yes _____ No Date Experience Requirements Met: _____
(mm/yyyy)

☐ **National Register of Health Services Providers in Psychology:** *A provider who does not qualify as an authorized clinical psychologist is to be offered the alternative of applying for provider status under another mental health provider category or of applying for listing in the National Register of Health Service Providers in Psychology.*

Are you listed in the National Register of Health Service Providers in Psychology?

_____ Yes _____ No

If yes, name of category: _____

*Please attach a copy of your registration

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

Certified Psychiatric Nurse Specialist Requirements

To verify each **Certified Psychiatric Nurse Specialist** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *Is a licensed, registered nurse*

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Education: *Has at least a **master's** degree in nursing with a specialization in psychiatric and mental health nursing*

Date Graduated: _____ Degree Earned: _____
(mm/yyyy)

Name of University: _____

In addition to **Licensure** and **Education**, please complete **one** of the following:

☐ **Clinical Experience:** *Has two years post-Master's experience degree practice in the field of psychiatric and mental health nursing, including an average of eight hours of direct patient contact per week*

_____ Yes _____ No Date Experience Requirements Met: _____

☐ **ANCC Certification:** If you do not meet the clinical experience requirements listed, you meet TRICARE requirements if you are certified by the American Nurses Association through the American Nurses Credentialing Center (ANCC). The following ANCC certifications meet this requirement. Please select the applicable certification:

The following ANCC certifications meet this requirement. Please select the applicable certification:

___ Adult or Psychiatric and Mental Health Clinical Nurse Specialist (CNS)
___ Child/ Adolescent- Psychiatric and Mental Health Clinical Nurse Specialist (CNS)
___ Adult Psychiatric Mental Health Nurse Practitioner (NP)
___ Family Psychiatric Mental Health Nurse Practitioner (NP)
___ Psychiatric and Mental Health Nurse Practitioner (NP)

Certification Number: _____

Original Certification Issue Date: _____ Certification Expiration Date: _____
(mm/dd/yyyy) (mm/dd/yyyy)

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

Clinical Social Worker (CSW) Requirements

To verify each **Clinical Social Worker** in your group meets TRICARE requirements, please provide the following information for **each** practitioner. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *licensed or certified as a CSW by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of CSWs, is certified by a national professional organization offering certification of CSWs*

License/Certification Number: _____

Original License /Certification Date: _____ Current Expiration Date: _____

Education: *Has at least a **master's** degree in social work from a graduate school of social work accredited by the **Council on Social Work Education***

Date Graduated: _____ Degree Earned: _____
(mm/yyyy)
Name of University: _____

Clinical Experience: *Has completed a minimum of two years or three thousand hours of post-Master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting*

_____ Yes _____ No Date Experience Requirements Met: _____
(mm/yyyy)

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

Revised: 03/19/2025

Supervised Mental Health Counselor (SMHC)

To certify you as a **Supervised Mental Health Counselor (SMHC)**, please provide the following information to confirm you meet TRICARE requirements. In the TRICARE program, a SMHC requires oversight by a physician. A Licensed Psychological Associate may provide services in the TRICARE program as a SMHC as long as they meet the requirements listed below. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Licensure: *licensed to practice as a mental health counselor by the jurisdiction where practicing*

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Education: *has a master's or higher-level degree in mental health counseling or allied mental health field from a regionally accredited institution*

Date Graduated: _____ Degree Earned: _____
(mm/yyyy)

Name of University: _____

Clinical Experience: *Has completed two years of post-master's experience which includes 3,000 hours of clinical work and 100 hours of face-to-face supervision.*

____ Yes ____ No Date Experience Requirements Met: _____
(mm/yyyy)

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

TRICARE Certified Mental Health Counselor Requirements (page 1 of 2)

To certify you as a **TRICARE Certified Mental Health Counselor (TCMHC)**, please provide the following information to confirm you meet TRICARE requirements. In the TRICARE program, A TCMHC does not require referral and oversight by a physician. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Licensure: *licensed for independent practice in mental health counseling by the jurisdiction where practicing*

License Number: _____

Original License Date: _____ Current Expiration Date: _____

Education: *has a master's or higher-level degree from a mental health counseling program of education and training accredited for Mental Health Counseling or Clinical Mental Health.*

Date Graduated: (mm/yyyy) _____ Degree Earned: _____

Name of University: _____

Please select the accreditation program your college/university is accredited by:

____ Council for Accreditation of Counseling and Related Education Programs (CACREP)

____ Council for Higher Education Accreditation (CHEA)*

____ Accrediting Commission for Community and Junior College Western, Association of Schools and Colleges (ACCJC-WASC)

____ Higher Learner Commission (HLC)

____ Middle States Commission on Higher Education (MSCHE)

____ New England Association of Schools and Colleges Commission on Institutions of Higher Education (NEASC-CIHE)

____ Southern Association of Colleges and Schools (SACS) Commission on Colleges

____ WASC Senior College and University Commission (WASC-SCUC)

____ Accrediting Bureau of Health Education Schools (ABHES)

____ Accrediting Commission of Career Schools and Colleges (ACCSC)

____ Accrediting Council for Independent Colleges and Schools (ACICS)

____ Distance Education Accreditation Commission (DEAC)

*Note- if your school is accredited by the Council for Higher Education Accreditation, you must have passed the National Clinical Health Counselor Examination (NCMHCE) to meet TRICARE requirements as a TCMHC.

Exam: *Has passed the **National Clinical Mental Health Counselor Examination (NCMHCE)** or the **National Counselor Examination (NCE)*.***

Please specify which examination:

____ National Clinical Mental Health Counselor Examination (NCMHCE)

____ National Counselor Examination (NCE)* ***must have passed the NCE prior to January 1, 2017.***

Date passed: (mm/dd/yyyy) _____

TRICARE Certified Mental Health Counselor Requirements (page 2 of 2)

Clinical Experience: *has a minimum of two years of post-master's degree supervised mental health counseling practice that includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision. This supervision must be provided by mental health counselors, psychiatrists, clinical psychologists, Certified Clinical Social Workers (CCSWs), TCMHCs, or Certified Psychiatric Nurse Specialists (CPNSs) who are licensed for independent practice in the jurisdiction where practicing and must be practicing within the scope of their licenses. Supervision must be conducted in a manner that is consistent with the guidelines regarding knowledge, skills, and practice standards for supervision of the American Mental Health Counselors Association (AMHCA)*

____ Yes _____ No Date Experience Requirements Met: _____
(mm/yyyy)

Note: *If the practitioner does not meet TRICARE Requirements to be a TCMHC, they may still qualify to be a Supervised Mental Health Counselor. Please complete the Supervised Mental Health Counselor requirements section.*

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

TRICARE Pastoral Counselor Requirements

To certify you as a **Pastoral Counselor,** please provide the following information to confirm you meet TRICARE requirements. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Practitioner Name: _____ Practitioner NPI: _____

Licensure: *If licensure/certification as a pastoral counselor is offered by the jurisdiction in which the provider is practicing, it is required in all cases, even if the jurisdiction offers it on an optional basis.*

License/Certification Number: _____

Original License/Certification Date: _____ Current Expiration Date: _____

In jurisdictions that **do not offer specific licensure or certification for pastoral counselors, the provider must be certified or be eligible for fellow or diplomate membership in the American Association of Pastoral Counselors (AAPC). If a provider is eligible for membership in the AAPC but is not a member, he/she **must submit documentation** obtained from the AAPC of such eligibility.*

_____ I have attached proof of membership as a fellow or diplomate member of the American Association of Pastoral Counselors (AAPC).

Or

_____ I have attached proof that I meet the requirements to become a fellow or diplomate member of the AAPC. (Membership information for the AAPC can be obtained by writing to the AAPC at 9504-A Lee Highway, Fairfax, Virginia 22031 or by calling AAPC at (703)-385-6967)

Education: *has at least a master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline*

Date Graduated: _____ Degree Earned: _____
(mm/yyyy)

Name of University: _____

Clinical Experience:

_____ Two hundred (200) hours of approved supervision in the practice of pastoral 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 pastoral 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 pastoral 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 pastoral counseling under approved supervision, involving at least 20 cases.

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

TRICARE Non-Network Christian Science Practitioner or Christian Science Nurse Requirements

To certify you as a **Christian Science Practitioner or Christian Science Nurse,** please provide the following information to confirm you meet TRICARE requirements. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

Practitioner Name: _____ Practitioner NPI: _____

Christian Science Practitioner or Christian Science Nurse must be listed or be eligible for listing in the Christian Science Journal.

____ I am currently listed in the Christian Science Journal.

Date Initially Listed in the Christian Science Journal: _____
(mm/yyyy)

If listed under a different name, please provide the name listed in the journal:

Name: _____

____ I am not currently listed but I am eligible to be listed in the Christian Science Journal. I have attached documentation of my eligibility from the Christian Science Journal.

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: _____ Date: _____

PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

State of _____

County of _____

_____ being first duly sworn, deposes and says: I hereby authorize PGBA, LLC / Health Net Federal Services in the state of South Carolina to accept my facsimile or stamp signature shown below.

(Facsimile, stamp or computer generated signature as it will appear on the claim form.)

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 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

Subscribed and sworn to before me this _____ day of _____ 20____.

_____
Notary Public in and for

_____ County, State of _____

(SEAL)

My Commission expires _____

Revised: 03/19/2025

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 _____ 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, State of _____

(SEAL)

My Commission expires _____