TRICARE NON-NETWORK PSYCHIATRIC NURSE SPECIALIST PROVIDER 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: 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.***

TRICARE Non-Network Psychiatric Nurse Specialist Application

First Name: _____ MI: ____ Last Name: _____

Gen: _____ Title: _____

Social Security #: _____ NPI#: _____

Are you employed by the US Government? ____ Yes ____ No

Do you sign your own claim forms? ____ Yes ____ No

If No, Signature Authorization forms are attached. Please complete these 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 and claims without signature will be returned without processing the claim for payment.

Do you maintain a solo practice? ____ Yes ____ No

Solo Practice Information

Solo Practice Tax ID: _____ NPI#: _____

Date you began using this Tax ID #: (mm/dd/yyyy) _____

Solo Physical Address (Street Address):

_____

_____

_____

Telephone #: _____

Fax #: _____

Solo Billing Address for this NPI:

_____

_____

_____

Billing Telephone #: _____

Email: _____

Do you work with an established group practice or institution? ____ Yes ____ No

Group Practice Information

If you practice at multiple locations, please provide the information below for each location.

Group Practice Name: _____

Group Practice Tax ID #: _____ NPI#: _____

Effective date of the group's Tax ID number or EIN (Date legal entity established): _____
(mm/dd/yyyy)

Date you began practicing with this group number: _____
(mm/dd/yyyy)

Group Physical Address (Street Address):

_____

_____

_____

Telephone #: _____

Fax #: _____

Group Billing Address for this NPI:

_____

_____

_____

Billing Telephone #: _____

Email: _____

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To certify you as a **Certified Psychiatric Nurse Specialist,** 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.

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: _____
(mm/yyyy)

☐ **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 professional body that meets the requirement of 32 CFR 199.6(c)(3)(iii)(G)*(4)* for a CPNS to be listed in a TRICARE-recognized, professionally sanctioned listing of clinical specialists in psychiatric mental health nursing.

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: _____

PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

State of _____

County of _____

_____ being first duly sworn, deposes and says: I hereby

authorize PGBA, LLC / TriWest Healthcare Alliance 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: 1/7/2025

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 _____

Revised: 1/7/2025