TRICARE PROVIDER CERTIFICATION APPLICATION

CLINICAL PSYCHOLOGIST (PSYD)

Per TRICARE requirements, TriWest Healthcare Alliance shall ensure all providers are TRICARE certified in accordance with 32 CFR 199.6 and TRICARE Policy Manual, Chapters 1 and 11.

Please submit the completed application package to provcerts@triwest.com.

Practitioner Information

*Required

First Name*:	MI:	Last Name*:	Suffix:

National Provider Identifier (NPI)*:	Gender*:	Date of Birth (MM/DD/YYYY)*:	SSN (XXX-XX-XXXX)*:
	○ M ○ F		

Phone Number (XXX-XXX-XXXX)*:	Email Address*:

Are you employed by the U.S. government?*

○ Yes ○ No

NOTE: Federal law (5 U.S.C. 5536) prohibits medical personnel, who are active duty service members or civilian employees of the government, compensation above their normal pay and allowances for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual medical provider, facility in which the care was rendered, or beneficiary/sponsor. Claims for TRICARE benefits will be denied in any situation where either a uniform member or civilian employee of the uniform 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.

Certification Information

To certify you as a **Clinical Psychologist (PsyD)**, please provide the following information to confirm you meet TRICARE requirements. Failure to provide complete and accurate information will delay the certification process and may negatively impact claims processing.

1. Attach a copy of your state license or certification and complete the following fields.

NOTE: If state licensure is available, it is required even if the state offers licensure on a voluntary basis.

State of Licensure/Certification*:	State License/Certification Number*:

License/Certification Effective Date (MM/DD/YYYY)*:	License/Certification Expiration Date (MM/DD/YYYY)*:

2. Complete the following fields regarding your education.

Do you possess a doctoral degree in psychology from a regionally accredited university?*

○ Yes ○ No

Name of University*:	
Degree Earned*:	Date Graduated (MM/DD/YYYY)*:

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3. Have you completed two years of 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

4. As an alternative to the second and third requirements listed above, are you listed in the National Register of Health Service Providers in Psychology? If yes, attach a copy of your registration listing.*

NOTE: 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 applying for listing in the National Register of Health Service Providers in Psychology.

○ Yes ○ No

Attestation

By signing below, I attest to meeting the above TRICARE requirements as well as confirm that the above information is accurate and complete to the best of my knowledge.

Signature*:	Date (MM/DD/YYYY)*: