TRICARE PROVIDER CERTIFICATION APPLICATION

MENTAL HEALTH COUNSELOR (MHC)

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 **Mental Health Counselor (MHC)**, 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: TRICARE Certified Mental Health Counselor (TCMHC) must be licensed or certified for independent practice in mental health counseling by the jurisdiction where practicing. In jurisdictions with two or more licenses allowing for differing scopes of independent practice, the licensed mental health counselor may only practice within the scope of the license he or she possesses.

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 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 Counseling?*

○ Yes ○ No

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

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Is the program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) or other approved accrediting agency per TRICARE Policy Manual, Chapter 11, Section 3.11?*

○ CACREP ○ Other Accrediting Agency

If not CACREP, select Other Accrediting Agency:

3. Have you completed 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?*

a. Supervision must be provided by mental health counselors, psychiatrists, clinical psychologists, certified clinical social workers, TRICARE certified mental health counselors, or certified psychiatric nurse specialists who are licensed for independent practice in the jurisdiction where practicing and who are practicing within the scope of their licenses.

b. 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.

○ Yes ○ No

4. Have you passed the National Clinical Mental Health Counselor Examination (NCMHCE) or an examination determined by the Defense Health Agency (DHA) as equal in scope, intent, and content to the NCMHCE?*

○ Yes ○ No

Date Exam Passed (MM/DD/YYYY):

Have you passed the National Counselor Examination?*

○ Yes ○ No

Date Exam Passed (MM/DD/YYYY):

5. For the TRICARE program, a Supervised Mental Health Counselor (SMHC) is an individual who does not meet the requirements of a certified mental health counselor but meets the requirements identified in the TRICARE Policy Manual, Chapter 11, Section 3.11, Paragraphs 2.2.1 through 2.23 and abides by the conditions of reimbursement identified in Paragraph 2.2.4.

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)*: