TRICARE PROVIDER CERTIFICATION APPLICATION

PHYSICIAN (MD, DO)

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*:

Primary Specialty*:	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 **Physician (MD, DO)**, 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.

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

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

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)*:

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