CERTIFIED MARRIAGE AND FAMILY THERAPIST CERTIFICATION FORM

*Required

General Statement

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.

Conflict of Interest and Dual Compensation

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 can exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selective basis.

Are you employed by the U.S. Government?*: ◯ Yes ◯ No

Providers employed or under a contract which provides payment to the individual professional provider by an institutional provider cannot be considered. Employees reimbursed by the institutional provider are not eligible for separate reimbursement outside the realm of the facility/institution.

Are you employed or under contract with a facility/institution?*: ◯ Yes ◯ No

Practitioner Information

First Name*:	MI:	Last Name*:	Suffix:
National Provider Identifier (NPI)*:	Sex*: ☐M ☐F	Date of Birth (MM/DD/YYYY)*:	SSN (xxx-xx-xxxx)*:
Phone Number (xxx-xxx-xxxx)*:	Email Address*:		

Point of Contact (POC) *Complete if different than Practitioner Information.*

POC First Name:	POC Last Name:	POC Title:
POC Phone Number (xxx-xxx-xxxx):	POC Email Address:	

Certification Information

To certify you as a **Certified Marriage and Family Therapist (CMFT)**, 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.

NOTE: Refer to the TRICARE Policy Manual, Chapter 11, Section 3.9 for CMFT requirements.

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State License/Certification **Required if practicing in a jurisdiction that offers licensure/certification.*

TRICARE Policy Manual, Chapter 11, Section 3.9, Paragraphs 2.1.2 and 2.1.2.1 states: The provider must be licensed or certified as a marriage and family therapist. If licensure/certification 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.

☐ Not Applicable – The jurisdiction in which I practice does not offer licensure/certification.

State (xx):	License/Certification Number:	
Original Issue Date:	Expiration Date:	License/Certification Specialty:

Attach a current copy of state license/certification.

Any disciplinary actions/sanctions against your license/certification? ◯ Yes ◯ No
If yes, you must submit a detailed and signed explanation.

National Certification **Required if practicing in a jurisdiction that does not offer licensure/certification.*

TRICARE Operations Manual, Chapter 11, Section 3.9, Paragraph 2.1.2.2 states: In jurisdictions that do not offer specific licensure or certification for marriage and family therapists, the provider must be certified or be eligible for full clinical membership in, the American Association for Marriage and Family Therapy (AAMFT), the national association that sets standards for the profession. If a provider is eligible for full clinical membership in the AAMFT but is not a member, he or she must submit documentation obtained from the AAMFT of such eligibility.

☐ I have attached proof of membership as a full clinical member of the AAMFT.

OR

☐ I have attached proof that I meet the requirements to become a full clinical member of the AAMFT.

Attach proof of membership as a full clinical member or that you meet the requirements to become a full clinical member of the AAMFT.

Education

TRICARE Policy Manual, Chapter 11, Section 3.9, Paragraph 2.1.1 states: The provider must meet education and training requirements as specified in 32 CFR 199.6.

Do you have at least a master's degree from a regionally accredited educational institution in an appropriate behavioral science field or mental health discipline?* ◯ Yes ◯ No

Attach a copy of your transcript that includes the name and address of the educational institution.*

Clinical Experience

TRICARE Policy Manual, Chapter 11, Section 3.9, Paragraph 2.1.1 states: The provider must meet education and training requirements as specified in 32 CFR 199.6.

Have you completed 200 hours of approved supervision in the practice of marriage and family, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours were in individual supervision? This supervision occurred preferably with more than one supervisor and included a continuous process of supervision with at least three cases.*

◯ Yes ◯ No

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AND

Have you completed 1,000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases?*

Yes No

OR

Have you completed 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 were individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years?*

Yes No

AND

Have you completed 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 marriage and family counseling under approved supervision, involving at least 20 cases?*

Yes No

Attach signed documentation confirming completion of TRICARE clinical experience requirements.*

Participation Agreement

TRICARE Policy Manual, Chapter 11, Section 3.9, Paragraph 2.1.2.3 states: The provider must enter into a participation agreement with the Defense Health Agency (DHA).

*Attach a copy of signed Participation Agreement for Certified Marriage and Family Therapist.**

Provider Roster

*Attach a completed TriWest Provider Roster Template.**

Attestation

By signing below, I attest that I meet the applicable TRICARE requirements and that the information provided in this form is true, accurate, and complete to the best of my knowledge.

Signature*:	Date of Signature*:

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