CERTIFIED PSYCHIATRIC NURSE SPECIALIST 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 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.

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 Psychiatric Nurse Specialist (CPNS)**, 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 3.7 for CPNS requirements.

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State License/Certification

TRICARE Policy Manual, Chapter 11, Section 3.7, Paragraph 2.1.1 states: A CPNS is an individual who is a licensed Registered Nurse (RN).

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

Attach a current copy of state license.*

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

Education

NOTE: Refer to the TRICARE Policy Manual, Chapter 11, Section 3.7, Paragraph 2.1.2.

Do you have at least a master's degree in nursing with a specialization in psychiatric and mental health nursing?*

◯ Yes ◯ No

Name of University*:	Degree Earned*:	Date Graduated*:

Clinical Experience

NOTE: Refer to the TRICARE Policy Manual, Chapter 11, Section 3.7, Paragraph 2.1.3.

Have you completed at least two years of post-master's 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

OR

National Certification

NOTE: Refer to the TRICARE Policy Manual, Chapter 11, Section 3.7, Paragraph 2.1.4.

Are you certified by the American Nurses Association through the American Nurses Credentialing Center (ANCC), the professional body that meets the requirement for a CPNS to be listed in a TRICARE-recognized, professionally sanctioned listing of clinical specialists in psychiatric mental health nursing?* ◯ Yes ◯ No

The following ANCC certifications meet this requirement. If applicable, please select your current designation and provide your certification information.

☐ Adult or Psychiatric and Mental Health Clinical Nurse Specialist (CNS)
☐ Child/Adolescent-Psychiatric and Mental Health CNS
☐ Adult Psychiatric Mental Health Nurse Practitioner (NP)
☐ Family Psychiatric Mental Health NP
☐ Psychiatric and Mental Health NP

Certification Number:	Effective Date:	Expiration Date:

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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.