LACTATION COUNSELOR 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

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.

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

Training Status Exclusion

NOTE: Title 32, CFR, Section 199.6 states that individual health care professionals who are allowed to render health care services only under direct and ongoing supervision as training to be credited towards earning a clinical academic degree or other clinical credential required for the individual to practice independently are excluded from TRICARE participation for the duration of such training.

Are you in an educational or training program required for your provider type*: ☐ 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 **Lactation Counselor**, 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 Operations Manual, Chapter 18, Section 10, 5.2 - Lactation Counselor Qualifications.

LACTATION COUNSELOR CERTIFICATION FORM

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

NOTE: TRICARE Operations Manual, Chapter 18, Section 10, Paragraph 5.2.1 states: If a state or local jurisdiction offers a lactation counselor licensure or certification, the provider shall maintain such license or certification, even if it is optional in the state or local jurisdiction.

☐ Not Applicable – The state 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

Per the TRICARE Operations Manual, Chapter 18, Section 10, Paragraph 5.2.1, the provider must hold a current certification by the following organization*:

☐ Academy of Lactation Policy and Practice, Inc. (ALPP) as a Certified Lactation Counselor (CLC)

Certification Number:	Effective Date:	Expiration Date:

Attach a current copy of national certification.

CPR Certification

NOTE: TRICARE Operations Manual, Chapter 18, Section 10, Paragraph 5.1.3 states: The provider must maintain a current adult, child, and infant CPR certification.

Issuing Organization*:	Issue Date*:	Expiration Date*:

Attach a current copy of CPR certification.*

Provider Roster

Attach a completed TriWest Provider Roster Template.*

Attestation

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

Signature*:	Date of Signature*: