



# PHYSICAL THERAPIST ASSISTANT (PTA) 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*:<br>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 **Physical Therapist Assistant (PTA)**, 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: TRICARE Policy Manual, Chapter 11, Section 3.16, Paragraph 2.0 states: PTAs shall meet Medicare's requirements for qualification as required by NDAA FY 2018, Section 721. Medicare's requirements for qualification can be found at Title 42, Code of Federal Regulations (CFR), Section 484.115, or successor regulation.



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I attest that I meet Medicare's requirements for qualification as required by NDAA FY 2018, Section 721.\*

Attest      Do Not Attest

## State License

NOTE: TRICARE Policy Manual, Chapter 11, Section 3.16, Paragraph 3.0 states: PTAs shall work within the requirements established by their state licensure and scope of practice.

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

***Attach a current copy of state license.\****

## Supervision

NOTE: TRICARE Policy Manual, Chapter 11, Section 3.16, Paragraph 4.1 - 4.2 states: A PTA shall be supervised by a licensed registered physical therapist. The requirements set below apply unless state or local laws or regulations are more stringent, in which case state or local requirements shall be followed. Refer to the TRICARE Policy Manual, Chapter 11, Section 3.16, Paragraph 4.0 - Supervision for more details.

|   |  |
|---|--|
| Supervising Physical Therapist First Name*: | Supervising Physical Therapist Last Name*: |
| Supervising Physical Therapist NPI*:        |  |

## 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*: |
|-------------|---------------------|