TRICARE Provider Certification Application

Registered Dietitian (RD)

Per TRICARE requirements, TriWest Healthcare Alliance shall ensure all providers are TRICARE certified in accordance with 32 CFR 199.6 and the TRICARE Policy Manual, Chapters 1 and 11.

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

Practitioner Information

*Required

Last Name*: First Name*: MI:

Suffix: National Provider Identifier (NPI)*: Sex*: Male Female

SSN (XXX-XX-XXXX)*: Date of Birth (MM/DD/YYYY)*:

Phone (XXX-XXX-XXXX)*: Email Address*:

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 **Registered Dietitian (RD)** 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 and complete the following fields.**

   NOTE: An RD must be licensed by the state in which the care is provided and must be under the supervision of a physician who is overseeing the episode of treatment or the covered program of services.

   State of Licensure*: State License Number*:

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

2. **Complete the following fields.**

   Do you provide Diabetes Self-Management Training (DSMT) via an accredited DSMT program?* Yes No

   If you provide DSMT, the fields below must be completed to meet TRICARE certification requirements.

   Have you received a bachelor's degree from an accredited U.S. college or university?* Yes No

   Are you accredited by the Academy of Nutrition and Dietetics' commission for a Didactic Program in Dietetics (DPD)?* Yes No

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Have you passed the Registration Examination for Dietitians as specified by state licensure?* ◯ Yes ◯ No

Are you under the supervision of a physician who is overseeing the DSMT program?* ◯ Yes ◯ No

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)*: _____