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Thank you for your interest in participating with TriWest Healthcare Alliance (TriWest) to serve the health care needs of TRICARE Beneficiaries and our nation's Veterans.

In order to participate in TriWest's provider network alongside the Department of Veterans Affairs (VA) and TRICARE, as well as to meet compliance obligations, we ask that you complete the credentialing process. The first step in this process is completion of the Council for Affordable Quality Healthcare (CAQH) application *or* TriWest credentialing application (starting on page 3).

If you participate in CAQH, please complete page 2 of this document with your demographic information and CAQH ID number. Please ensure your CAQH profile is completed and up to date. After your application is complete on CAQH, TriWest will retrieve your information and perform primary source verification of your credentials. Please ensure you authorize TriWest to access your profile on CAQH or use blanket authorization. If TriWest is not authorized to access your CAQH profile, TriWest will not be able to complete your credentialing process and you will not be able to see patients.

Please include your W9 form.

If you do not participate in CAQH, please skip to page 3 and complete TriWest Credentialing Application and attach supporting documentation listed.

TriWest has partnered with a national credentials verification organization, **Aperture Credentialing, LLC (Aperture)**, to handle credentialing/re-credentialing of their network providers. You may receive requests from Aperture for additional information.

Upon the initial credentialing, healthcare providers are scheduled for re-credentialing every three years. Our organization will proactively contact you, or your designated credentialing contact, several months before your credentialing expires. We strongly emphasize the importance of maintaining accurate demographic and credentialing contact information to avoid any disruption in your provider re-credentialing status. We kindly request that you promptly notify us of any changes to your credentialing information.

We would like to inform you that our email system is configured to restrict the receipt of ZIP files and any attachments exceeding 5 megabytes (MB) in size. To transmit larger files, please either split them into multiple, smaller emails or contact TriWest for assistance with the secure email platform Move IT, ensuring compliance with our communication standards.

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TRIWEST HEALTHCARE ALLIANCE®

CAQH PROVIDER INFORMATION

PROVIDER NAME, DEGREE			
PROVIDER DATE OF BIRTH			
PROVIDER SSN #		**PROVIDER CAQH #**	
PROVIDER NPI/TYPE1 NPI #			
ACTIVE DUTY MEMBER ☐ Yes ☐ No		**PCM** ☐ Yes ☐ No	
SUPERVISING PHYSICIAN NPI # (Required for Physician Assistants)			
For CRNA: Do you work in a hospital or ASC? ☐ Yes ☐ No			
For CRNA: Do you prescribe medication? ☐ Yes ☐ No			

PRACTICE LOCATIONS FOR TRIWEST CONTRACT

PRIMARY PRACTICE DBA NAME	PRIMARY PRACTICE W9 NAME
PRIMARY PRACTICE ADDRESS	PRIMARY PRACTICE CITY, STATE, ZIP
PRIMARY PRACTICE PHONE NUMBER	PRIMARY PRACTICE FAX NUMBER
PRIMARY PRACTICE EMAIL	
TAX ID	GROUP NPI (NPI ON CLAIM)
BILLING/REMIT ADDRESS	BILLING/REMIT ADDRESS CITY, STATE, ZIP
BILLING/REMIT PHONE NUMBER	BILLING/REMIT FAX NUMBER
MAILING ADDRESS	MAILING CITY, STATE, ZIP
MAILING PHONE NUMBER	MAILING FAX NUMBER
MAILING PRACTICE EMAIL	

Please submit additional practice location information on a separate sheet.

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TriWest Practitioner Credentialing Application

To expedite processing of your application, please complete this application in its entirety and attach the following documentation.

Incomplete applications will not be accepted.

Copy of ECFMG certificate (if foreign trained)

Copy of current unexpired state license(s)

Copy of current unexpired DEA certificate, if applicable

Copy of current unexpired state controlled substances license (if applicable)

Copy of Board Certificate

Copy of current unexpired malpractice declaration sheet (evidence of professional liability insurance which indicates coverage limits and expiration dates and name of provider must be on the cover sheet or if in a group on a list of provider's letterhead from the insurance company)

Current resume / Curriculum Vitae, (Use month and year to indicate time for education, training and work history. All gaps over 6 months must be explained)

Please type or print legibly and ensure the attestation and release forms are signed and dated by the practitioner. If the application is not fully complete, signed and dated, it will not be processed. Please use additional sheets if you need to provide additional information.

The application can be submitted to the contact information (email, fax or by mail) on the cover letter.

Applicants have the right to review the information submitted in support of their credentialing application. Please contact the TriWest Credentialing Department (credentialing@triwest.com) if you would like to review your credentialing application.

Pursuant to Department of Veteran Affairs and TRICARE imposed guidelines and procedures, TriWest must adhere to certain specialty specific requirements. Please refer to the TriWest Healthcare Alliance Provider Eligibility Requirements included in contracting introduction email, or contact a Direct Contracting Specialist for more details.

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CREDENTIALING APPLICATION

PERSONAL DATA

PROVIDER'S NAME (Last Name, First Name, MI, Degree)	MAIDEN NAME (If Applicable)	SOCIAL SECURITY NUMBER

DATE OF BIRTH	GENDER	PLACE OF BIRTH (City, State, Country)	FOREIGN LANGUAGES:
	❒ M ❒ F		❒ Speak ❒ Read ❒ Write

Individual NPI #:	Medicare UPIN:	U.S. Citizen? ❒ Yes ❒ No	If you are not a U.S. Citizen, are you lawfully authorized to work in the U.S.? ❒ Yes ❒ No

HOME ADDRESS (No., Street)	HOME CITY	HOME STATE	HOME ZIP CODE

SUPERVISING PHYSICIAN (Required for Physician Assistant):	EMERGENCY TELEPHONE:

For CRNA: Do you work in a hospital or ASC? ❒ Yes ❒ No	For CRNA: Do you prescribe medication? ❒ Yes ❒ No

SPECIALTY/BOARD CERTIFICATIONS

LIST ALL SPECIALTIES PRACTICED, BEGIN WITH PRIMARY SPECIALTY

SPECIALTY	CERTIFIED	NAME OF BOARD	DATE (S) CERTIFIED	DATE CERT. EXPIRES
	❒Yes ❒No ❒Eligible	If eligible, date exam taken:		
	❒Yes ❒No ❒Eligible	If eligible, date exam taken:		
	❒Yes ❒No ❒Eligible	If eligible, date exam taken:		

LICENSE/CERTIFICATION INFORMATION

PLEASE LIST ALL CURRENT AND PREVIOUS LICENSES HELD IN ALL JURISDICTIONS

ATTACH A COPY OF ALL LICENSES

State of Issue	Number	Current	Original Issue Date	Current Issue Date	Expiration Date
		❒ Yes ❒ No			
		❒ Yes ❒ No			
		❒Yes ❒ No			
		❒ Yes ❒ No			
		❒ Yes ❒ No			

DEA (attach copies)

DEA #	Effect:	Expire:
Controlled Dangerous Substance Reg.		
Therapeutic Agent Reg.		

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PRACTICE/OFFICE INFORMATION

BILLING/REMIT

PRACTICE NAME	BILLING COMPANY NAME (if different)		
DATE YOU JOINED GROUP/HOSPITAL	TAX ID	GROUP NPI	MEDICARE PIN
BILLING/REMIT ADDRESS	CITY		
	STATE	ZIP CODE	
BILLING/REMIT PHONE	BILLING/REMIT FAX		
BILLING/REMIT OFFICE EMAIL	RECEIVE MAIL AT THIS LOCATION: Y/N		
LIST ALL PROVIDERS ASSOCIATED WITH THIS PRACTICE:			

MAILING INFORMATION

PRACTICE NAME			
PHYSICAL STREET ADDRESS	CITY		
	STATE	ZIP CODE	
OFFICE PHONE / OFFICE FAX	OFFICE E MAIL ADDRESS		

PRIMARY PRACTICE LOCATIONS - Location #1

PRACTICE NAME (if different than billing practice name)	TYPE OF PRACTICE: ❒Solo ❒Group/Partnership ❒Hospital Based		
DATE YOU JOINED GROUP/HOSPITAL	TAX ID	GROUP NPI	MEDICARE PIN
PHYSICAL STREET ADDRESS	CITY		
	STATE	ZIP CODE	
OFFICE PHONE / OFFICE FAX	OFFICE E MAIL ADDRESS		
FOREIGN LANGUAGE(S) IN OFFICE: ❒ Speak ❒ Read ❒ Write	ARE YOU CURRENTLY ACCEPTING NEW PATIENTS: ❒ YES ❒ NO		
ANY PRACTICE RESTRICTIONS? (SPECIFY)	OFFICE HOURS: MONDAY_____ TUESDAY_____ WEDNESDAY_____THURSDAY_____FRIDAY_____ SATURDAY _____ SUNDAY_____		

Please submit additional practice location information on a separate sheet.

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TriWest HEALTHCARE ALLIANCE®

EDUCATION AND TRAINING
(ATTACH ADDITIONAL SHEETS IF NECESSARY)

MEDICAL OR PROFESSIONAL EDUCATION

SCHOOL/INSTITUTION	ADDRESS, CITY, STATE, ZIP	DATES (Month/Year)	DEGREE
		From: To:	
		From: To:	
		From: To:	
		From: To:	
		From: To:	

POST GRADUATE TRAINING/SUPERVISED EXPERIENCE INTERNSHIP/RESIDENCIES/FELLOWSHIPS

SCHOOL/INSTITUTION	ADDRESS, CITY, STATE, ZIP	DATES (Month/Year)	SPECIALTY	TYPE
		From: To:		❒ Internship ❒ Residency ❒ Fellowship
		From: To:		❒ Internship ❒ Residency ❒ Fellowship
		From: To:		❒ Internship ❒ Residency ❒ Fellowship
		From: To:		❒ Internship ❒ Residency ❒ Fellowship
		From: To:		❒ Internship ❒ Residency ❒ Fellowship

ACADEMIC APPOINTMENTS

TITLE	INSTITUTION/ADDRESS	DATES OF APPOINTMENT

MEDICAL STAFF APPOINTMENTS
LIST ALL CURRENT AND PAST APPOINTMENTS (ATTACH ADDITIONAL LISTING AS NECESSARY)

STATUS/SPECIALTY	FACILITY/ADDRESS	DATES OF APPOINTMENT

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CHRONOLOGICAL PROFESSIONAL PRACTICE EXPERIENCE
(MOST RECENT FIRST - ATTACH ADDITIONAL SHEETS AS NECESSARY)

ORGANIZATION/PRACTICE:	PHONE:	DATE FROM	DATE TO
ADDRESS:	POSITION TITLE:	SUPERVISOR:	
DUTIES/RESPONSIBILITIES:			

ORGANIZATION/PRACTICE:	PHONE:	DATE FROM	DATE TO
ADDRESS:	POSITION TITLE:	SUPERVISOR:	
DUTIES/RESPONSIBILITIES:			

WORK HISTORY GAPS Please provide an explanation for any gaps in the last 5 years

MALPRACTICE/LIABILITY INSURANCE
(Attach copy of current malpractice certificate)

CURRENT CARRIER:		POLICY #:	
ADDRESS:	City		
	State	Zip	
AMOUNTS OF COVERAGE:	ISSUE DATE:	EXPIRATION DATE:	

MILITARY INFORMATION

Are you subject to mobilization as a member of a reserve or Guard unit, as an individual mobilization augmentee, or subject to recall to active duty as a retired military provider? ❒ Yes ❒ No

If Yes to above, which Service Status applies? (Circle/check one)	Which Service Branch applies? (Circle/check one)
❒ Active Reserve ❒ Active National ❒ Guard Retired ❒ Reserve Retired ❒ Regular ❒ Retired National Guard	❒ US Army ❒ Army National Guard ❒ US Air Force ❒ Air National Guard ❒ USPHS Commissioned Corps NOAA ❒ US Navy ❒ US Coast Guard ❒ US Marine Corps ❒ Commissioned Corps

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	QUESTIONNAIRE/PERSONAL STATEMENTS **A complete detailed written explanation is required for any question that is answered "yes". If any question does not apply write N/A and a complete detailed written explanation is required**	Yes	No
1	Do you currently have any physical impairment or disability that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?	❒	❒
2	Do you currently have any mental impairment or disability that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?	❒	❒
3	Do you currently have any substance abuse problems that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?	❒	❒
4	Have you received treatment for substance abuse related conditions?	❒	❒
5	Have you been convicted of a felony, fraud, narcotics offense, moral, or any other type of ethical crime?	❒	❒
6	Have you been convicted of a misdemeanor case?	❒	❒
7	Has any license or certification to practice in any jurisdiction been limited, restricted, revoked, suspended, involuntarily relinquished or voluntarily relinquished while under investigation, terminated, subjected to disciplinary action or otherwise acted upon in an adverse manner?	❒	❒
8	In the past 5 years have you been sanctioned or penalized by any hospital, licensing board, government entity or managed care organization?	❒	❒
9	In the past 5 years, have you been involuntarily refused or denied membership on a hospital medical staff?	❒	❒
10	In the past 5 years, have your specific clinical privileges at a facility in any jurisdiction been denied, limited, suspended, diminished, revoked, withdrawn or denied renewal?	❒	❒
11	Have you been subjected to disciplinary action by any medical organization?	❒	❒
12	Have you been subjected to any claim(s) or under investigation for unethical conduct?	❒	❒
13	In the past 10 years, have you been the subject of a malpractice claim or are there currently pending malpractice claims, suits, settlements, arbitration proceedings, or complaints filed involving your professional practice?	❒	❒
14	In the past 10 years, have any judgments been made against you or settlements paid by or for you in any professional liability claim?	❒	❒
15	In the past 10 years, have you been denied liability insurance, in whole or in part, or has your policy ever been canceled, involuntarily restricted, denied renewal, or rated up because of the nature of volume of claims against you?	❒	❒
16	Has your DEA license or narcotics registration been suspended or revoked?	❒	❒

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PROFESSIONAL LIABILITY CLAIMS HISTORY DETAIL/EXPLANATION

Please complete this form for every professional liability case filed against you in the last 10 years, whether currently open, settled, dismissed or judgments rendered. Please answer the following questions for EACH claim. Duplicate this page as necessary.

Patient name:	Plaintiff name (if other than patient):		
Your involvement in the case (Attending, consulting)	Date of occurrence (month/day/year)		
Your status in the case (Primary or co-defendant)	Date claim was filed (month/day/year)		
Professional liability insurance carrier involved			
Additional defendants			
Describe the allegation and alleged injury to the patient			
Provide explanation or information of the events leading to the allegation			
Claimant/Plaintiff filed suit in court? ❒ Yes ❒ No	Court Case #	State	County/Parish
Federal Court (US District Court) Case Number	District		
Present status of claim ❒ Open ❒ Closed			
If closed, indicate the method of resolution: ❒ Dismissed Date: _____ ❒ Settled (with prejudice) Date: _____ ❒ Settled (without prejudice) Date: _____ ❒ Judgment for defendant(s) Date: _____ ❒ Judgment for plaintiff(s) Date: _____	Amount paid on your behalf (if any)		

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CERTIFICATION/ATTESTATION AND CONSENT TO THE INSPECTION OF RECORDS AND DOCUMENTS RELEASE OF INFORMATION AND LIABILITY

I certify and attest to the fact that all the information submitted by me in this application is true and accurate to the best of my knowledge and belief.

I authorize TriWest Healthcare Alliance, its professional staff and legal representatives for the purpose of evaluating my professional competence, character, criminal history and ethical conduct, to contact and consult with administrators and members of the professional staff of any treatment facility, institution, professional society, school, employer, law enforcement agency, or practice with which I have been associated. In addition, I consent to the inspection by TriWest Healthcare Alliance, its professional staff and legal representatives of all records and documents, including health records at other treatment facilities that may be material for evaluation of my professional qualifications. I also release from liability all individuals or organizations for their acts performed in good faith and without malice who honestly initiate and respond to the inquiries authorized for use by TriWest Healthcare Alliance. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

_____ _____

Practitioner Signature Date

PLEASE ATTACH

DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE FORM W-9