Allied Health professional provider certification application

Required:

Practitioner EIN/SSN #: ________________

Practitioner NPI #: ________________

Request date: ____________________________

Name: ____

Phone: ______________________ National Provider Identifier (NPI) #: ____________________

Federal tax ID #: ____________________ ☐ EIN ☐ SSN Are you joining an established group practice? ☐ Yes ☐ No

If Yes, group name: ____

Date you began filing with group: ____________________ Group NPI #: ____________________

You may complete the *Special authorization* form enclosed if the group will bill on your behalf.
You may complete the *Authorized signer* form enclosed if a representative will be signing claim forms on your behalf.

Office location (street address): ____

City: ______________________ State: ______________ ZIP: ______________

Billing address (if different): ____

City: ______________________ State: ______________ ZIP: ______________

Office phone #: ________________ Billing phone #: ________________ Fax #: ________________

I am applying for certification as a:

☐ Certified Registered Nurse Anesthetist (CRNA) ☐ Anesthesiologist Assistant (AA)

POC information if additional information is needed (may be practitioner or group representative):

Name: ____

Phone #: ______________________________

Email: ____

To apply for certification as a TRICARE-authorized provider, read and complete all sections of this application and return it with all attachments by fax or mail to:

Please return application by fax/mail to:

Fax
(608) 221-7535

Mail
TRICARE East Provider Certification
PO Box 7870
Madison, WI 53707-7870

XPLR0822-D

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Licensure

Enclose copy of licensure/certification: License #: ______________ ☐ Temporary/Limited ☐ Permanent

Issuing state: ______________ Date license was first issued: ______________ Expiration date: ______________

Medicare #: ______________ Primary specialty: ______________

If licensing is not required, but you are a member (or eligible) in the state or national association setting standards for your profession, please indicate. ☐ State ☐ National ☐ Member ☐ Eligible

State or national organization: ______________

Education

Have you earned a degree for your specialty from an accredited institution? ☐ Yes ☐ No

If Yes, school name: ______________

Address: ______________

City: ______________ State: ______________ ZIP: ______________

Degree earned: ______________ Year earned: ______________

Are you transferring from another state where you had an established practice? ☐ Yes ☐ No If Yes, state: ______________

Are you:

Hospital-salaried/employed physician? ☐ Yes ☐ No

National Health Service Corporation (NHSC) physician? ☐ Yes ☐ No

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

Intern? ☐ Yes ☐ No

Teaching-setting physician? ☐ Yes ☐ No

Dual Compensation/Conflict of Interest Statement for TRICARE providers:

Federal law (*Title 5 U.S.C. 5536*) prohibits medical personnel, who are active duty 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 who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. 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 or under a contract which provides for payment to the individual professional provider by an institutional provider? If you are, your application cannot be considered. Hospital employees are not eligible for additional provider numbers outside the realm of the hospital.

Signature of provider: ______________ Date: ______________

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Additional TRICARE requirements per specialty:

Certified Registered Nurse anesthetist (CRNA):

1. Certified by the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA)

NBCRNA #: ______________________________

Anesthesiologist Assistant (AA):

1. Works under direct supervision of a licensed anesthesiologist
2. Graduate of Masters level anesthesiologist assistant educational program which meets the following criteria:
   a. Is accredited by the Commission on Accreditation of allied health educational programs (CAAHEP)
   b. Includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background

Name of Master's level program: ______________________________

Institution name/state: ______________________________

Name of supervising physician: ______________________________

License number/state of supervising physician: ______________________________

I meet the criteria outlined above for my specialty.

Signature of provider: ______________________________ Date: ______________

Please notify us of any changes related to your provider file information (name, address, specialty, tax number, group affiliations, etc.)

Please return application by fax/mail to:

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Special authorization

I certify that I am an associate with the ____
(Name of clinic association)

whose address is ____

I also certify that I am not an intern or resident, and that I am licensed as indicated in this state (or, if licensing is not required, that I am eligible for membership in the national or state organization setting the standards for my allied science specialty).

I hereby authorize any of the duly authorized representatives of the above-named organization as my agents to submit on my behalf claims for services provided TRICARE beneficiaries, and to receive on my behalf any payments which may be made pursuant to submission of such claims. It is understood and agreed that claims will be submitted only for services which are medically indicated for the proper care of the patient, and the services (where provided by other than a physician or dentist) were ordered by the attending physician or dentist and that the services were actually furnished.

I understand that I may withdraw this authorization at any time by giving written notice of such fact to the above-named organization.

I also agree to hold the United States and its fiscal administrators under TRICARE harmless for any losses that might occur to me as the result of any action on the part of representatives of the above- named organization after payment has been made by the United States or its fiscal administrators to said organizations for services which I have rendered, pursuant to a billing and claim submitted in my behalf in accordance with the terms of this agreement.

I also understand the making or conspiring to make a false, fictitious or fraudulent claim against the United States or one of its fiscal administrators renders such person liable to prosecution under applicable Federal Law.

Name: ______________________ Title: ______________________

Signature: ______________________ Specialty and SSN: ______________________

State license # if required by organization: ______________________

Name: ______________________ Title: ______________________

Signature: ______________________ Specialty and SSN: ______________________

State license # if required by organization: ______________________

Name: ______________________ Title: ______________________

Signature: ______________________ Specialty and SSN: ______________________

State license # if required by organization: ______________________

Name: ______________________ Title: ______________________

Signature: ______________________ Specialty and SSN: ______________________

State license # if required by organization: ______________________

If a provider elects to use a facsimile signature (rubber stamp) or allow a representative to sign his/her name for certification of the services rendered, it is a TRICARE requirement that we have an authorization from the provider. Please complete the requested information on the authorization form below and return it to our office to assure prompt adjudication of your claims. Thank you.

Authorized signer

Hospital/Clinic name: ______________________________ IRS tax #: ______________________________

Address: ____

City: ______________________________ State: ______________ ZIP: ______________

Each of the below named representatives of this organization are hereby authorized to complete and sign all claim forms required by TRICARE and any related documentation that might be required by fiscal administrators of TRICARE on behalf of all physicians, dentists and other allied science professional staff members for authorized services, care and treatment rendered in the hospital or clinic to TRICARE patients.

The undersigned understands that this is continuing authorization and that the data on such claim forms is entered with the same authority, accuracy and effect as though executed by a member of the professional staff on whose behalf the form is completed. We understand that this authorization shall remain in effect until canceled or modified in writing by the undersigned or our successors in office.

The agents' signatures and typed names and official titles with the organization as authorized above as follows:

____

Signature Printed name Official title

____

Signature Printed name Official title

____

Signature of president (or authorized officer of the governing body of the hospital, clinic or association) Date

Computer generated facsimile or rubber stamp authorization

Hospital/Clinic name: ______________________________ IRS tax #: ______________________________

National Provider Identifier (NPI) #: ______________________ Address: ______________________________

City: ______________________________ State: ______________ ZIP: ______________

____ being first duly sworn, deposes and says: I hereby authorize Humana Military to accept my facsimile or stamp signature, shown below, as my true signature for all purposes under the TRICARE program in the same manner as if it were my actual signature.

______________________________ ______________________________

Actual signature Facsimile or stamp signature

Subscribed and sworn to before me this ______________ (date) day of ______________ (month), 20 ______ .

Notary public in and for ____ county,

state of ____ , my commission expires (SEAL)

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