Mental health counselor provider certification application

Required:

Practitioner EIN/SSN #: _____

Practitioner NPI #: _____

A TRICARE Certified Mental Health Counselor (TCMHC) is an independent provider who does not require referral and oversight by a physician in order to receive reimbursement for service to a beneficiary. If you do not meet the requirements to be a TCMHC, you may qualify to be a Supervised Mental Health Counselor (SMHC). For information on certification requirements, refer to the *TRICARE Policy Manual, Chapter 11, Sec 3.11*

Request date: _____

Applicant information

Name: _____

Phone #: _____ NPI #: _____

Federal tax ID #: _____ ☐ EIN ☐ SSN Solo practice: ☐ Yes ☐ No ☐ Both

If you are filing your taxes under a Federal Tax Identification number because you are incorporated or belong to an incorporated group/ professional association, you must also complete a Group Application form.

Are you joining an established group practice? ☐ Yes ☐ No

If Yes, group name: _____ Group NPI #: _____

Date you began filing with the group: _____

Office location (street address): _____

City: _____ State: _____ ZIP: _____

Billing address (if different): _____

City: _____ State: _____ ZIP: _____

Office phone #: _____ Office fax #: _____ Billing phone #: _____

You may complete the Special Authorization form if the group will bill on your behalf. You may complete an Authorized Signer form if a representative will be signing claim forms on your behalf.

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.

Please return application by fax/mail to:

Fax
(608) 221-7535

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

Humana Military | TRICARE®

Mental health counselor provider certification application

TCMHCs must meet the following requirements:

☐ Must be licensed for independent practice in mental health counseling by the jurisdiction where practicing. In jurisdictions that offer two or more licenses allowing for differing scopes of independent practice, the licensed mental health counselor may only practice within the scope of licensure he or she possesses

☐ Has passed the National Clinical Mental Health Counselor Examination (NCMHCE) or an examination determined by the director, DHA as equal in scope, intent and content to the NCMHCE

☐ Meets one of the following (please check the option that applies to you):

☐ A combination of:

- Possesses a master's or higher-level degree from a mental health counseling program of education and training accredited for mental health counseling or clinical mental health counseling by the Council for Accreditation of Counseling and Related Educational Programs (CACREP); **AND**
- Has a minimum of two years of post-master's degree supervised mental health counseling practice that includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision. This supervision must be provided by mental health counselors, psychiatrists, clinical psychologists, certified Clinical Social Workers (CSW), TCMHCs, or Certified Psychiatric Nurse Specialists (CPNS) who are licensed for independent practice in the jurisdiction where practicing and must be practicing within the scope of their licenses. Supervision must be conducted in a manner that is consistent with the guidelines regarding knowledge, skills and practice standards for supervision of the American Mental Health Counselors Association (AMHCA); **OR**

☐ At any point prior to January 1, 2017, has met these requirements:

- Possesses a master's or higher-level degree from a mental health counseling program of education and training accredited for mental health counseling or clinical mental health counseling by CACREP and has passed the National Counselor Examination (NCE) or NCMHCE
- Pursuant to Section 716 of the NDAA for FY 2016, prior to January 1, 2021, an individual satisfies the requirement to "hold a master's or higher-level degree from a mental health counseling program of education and training accredited for Mental Health Counseling or Clinical Mental Health Counseling by CACREP" if the individual holds a master's degree or doctoral degree in counseling from a program that is accredited by any of the following:
  - Accrediting Commission for Community and Junior Colleges Western, Association of Schools and Colleges (ACCJC-WASC)
  - Higher Learning Commission (HLC)
  - Middle States Commission on Higher Education (MSCHE)
  - New England Association of Schools and Colleges Commission on Institutions of Higher Education (NEASC-CIHE)
  - Southern Association of Colleges and Schools (SACS) Commission on Colleges
  - WASC Senior College and University Commission (WASC-SCUC)
  - Accrediting Bureau of Health Education Schools (ABHES)
  - Accrediting Commission of Career Schools and Colleges (ACCSC)
  - Accrediting Council for Independent Colleges and Schools (ACICS)
  - Distance Education Accreditation Commission (DEAC); AND
- Possesses a master's or higher-level degree from a mental health counseling program of education and training accredited for mental health counseling or clinical mental health counseling from an educational institution accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation and has passed the NCMHCE; **AND**
- Has a minimum of two years of post-master's degree supervised mental health counseling practice that includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision. This supervision must be provided by mental health counselors, psychiatrists, clinical psychologists, certified CCSWs, TCMHCs, or CPNSs who are licensed for independent practice in the jurisdiction where practicing and that is consistent with the guidelines regarding knowledge, skills and practice standards for supervision of the AMHCA

Mental health counselor provider certification application

I certify that all of the above information is true and correct to the best of my knowledge and I meet the TRICARE requirements to be a TCMHC.

Signature of provider: _____ Date: _____

If you do not meet the requirements to be a TCMHC, you may qualify to be a SMHC. A SMHC must meet the following requirements:

☐ Must possess a minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited institution; **AND**
☐ Has two years of post-masters experience which includes 3,000 hours of clinical work and 100 hours of face-to-face supervision; and
☐ Is licensed or certified to practice as a mental health counselor by the jurisdiction where practicing; **AND**
☐ May only be reimbursed when the following criteria are met:

- The TRICARE beneficiary is referred for therapy by a physician; **AND**
- A physician is providing ongoing oversight and supervision of the therapy being provided; **AND**
- The SMHC certifies on each claim for reimbursement that written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician.

I certify that all of the above information is true and correct to the best of my knowledge and I meet the TRICARE requirements to be a SMHC.

Signature of provider: _____ Date: _____

Licensure

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

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

Medicare #: _____ Primary specialty: _____

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

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: _____

Humana Military | TRICARE®

Mental health counselor provider certification application

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.

Are you: Hospital-salaried/employed? ☐ Yes ☐ No Employed by the US government? ☐ Yes ☐ No

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:

Fax
(608) 221-7535

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

Humana Military | TRICARE®

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: _____

Humana Military | TRICARE®

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)

Please return application by fax/mail to:

Fax
(608) 221-7535

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

Humana Military | TRICARE®

XPLR0322-C