CHAPTER 10
ADDENDUM E

APPLICATION FORM FOR CORPORATE SERVICES PROVIDERS

(TRICARE Contractor's Letterhead)

Application for TRICARE-Provider Status

OMB No. 0720-0020
Expires XXX XX, XXXX

Draft pending OMB Approval

CORPORATE SERVICES PROVIDER

The public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0020), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR APPLICATION TO THE ABOVE ADDRESS.

DIRECTIONS

- *To apply for certification as a TRICARE-authorized provider, read and complete all sections of this application and return it with all attachments to the following address:*

(Contractor's Name
Contractor's Provider Certification Unit
Address)

- *For inquires, please call (Contractor's provider-inquiry telephone number).*

Provider name:

NOTE: All Applications must be signed by the chief executive officer and dated.

The above-named provider has applied to become a TRICARE-authorized provider. The signee certifies that the information in this application and attachments is true and accurately represents and depicts the above-named provider.

Chief executive officer

Date

Application for TRICARE-Provider Status: **INSTITUTION/CORPORATE SERVICES PROVIDER**

Identification Information:

Name: ______________________________

Corporate/foundation name if different: ______________________________

ADDRESS:

Physical location (street, city, state, ZIP): ______________________________

Mailing address (if different): ______________________________

Area code and TELEPHONE NUMBER: ______________________________

Area code and FACSIMILE NUMBER: ______________________________

TAX ID NUMBER: ______________________________

Are you a MEDICARE provider? Yes ____ No_____

If yes: Medicare certification number: ______________________________

Medicare Category: ______________________________

Medicare acceptance date: ______________________________

Are you JCAHO accredited? Yes ____ No_____

If yes: JCAHO classification: ______________________________

Original JCAHO classification date: ______________________________

Current JCAHO classification dates FROM: ______________________________

TO: ______________________________

STATE license classification: ______________________________

Dates of state licensure FROM: ______________ TO: ______________

Are you certified by a national board? Yes ___ No____

If yes: Name of board: ______________________________

Effective date of certification: ______________________________

IMPORTANT: Please attach copies of applicable Medicare, JCAHO, state, and national board certificates/licenses.

ENCLOSURE 1 PARTICIPATION AGREEMENT

In order to receive payment under TRICARE, ______________________________
dba ______________________________, as the provider of services agrees:

1. Not to charge a beneficiary for the following:

a. Services for which the provider is entitled to payment from TRICARE;

b. Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements;

c. Services not medically necessary and appropriate for the clinical management of the presenting illness, injury, disorder or maternity;

d. Services for which a beneficiary would be entitled to payment but for a reduction or denial in payment as a result of quality review; and

e. Services rendered during a period in which the provider was not in compliance with one or more conditions of authorization:

2. To comply with applicable provisions of 32 CFR 199 and related TRICARE policy;

3. To accept the TRICARE determined allowable payment combined with the cost-share, deductible, and other health insurance amounts payable by, or on behalf of, the beneficiary, as full payment for TRICARE allowed services;

4. To collect from the TRICARE beneficiary those amounts that the beneficiary has a liability to pay for the TRICARE deductible and cost-share/copayment;

5. To permit access by the Executive Director, TMA, or designee, to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state or private agencies or organizations;

6. To provide to the Executive Director, TMA, or designee (e.g., Managed Care Support Contractor), prompt written notification of the provider's employment of an individual who, at any time during the twelve months preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly, for decisions regarding Department of Defense payments to the provider;

7. To cooperate fully with a designated utilization and clinical quality management organization which has a contract with the Department of Defense for the geographic area in which the provider renders services;

8. Comply with all applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/copayment may be expected;

9. To maintain clinical and other records related to individuals for whom TRICARE payment was made for services rendered by the provider, or otherwise under arrangement, for a period of 60 months from the date of service;

10. To maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, the methods, modalities or means of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment;

ENCLOSURE 1 PARTICIPATION AGREEMENT (CONTINUED)

11. To refer TRICARE beneficiaries only to providers with which the referring provider does not have an economic interest, as defined in 32 CFR 199.2;

12. To limit services furnished under arrangement to those for which receipt of payment by the TRICARE authorized provider discharges the payment liability of the beneficiary; and

13. Meet such other requirements as the Secretary of Defense may find necessary in the interest of health and safety of the individuals who are provided care and services.

TRICARE Management Activity (TMA) agrees to:

Pay the above-named provider the full allowable amount less any applicable double-coverage, cost-share/copayment, and deductible amounts.

This agreement shall be binding on the provider and TMA upon acceptance by the Executive Director, TMA, or designee.

This agreement shall be effective until terminated by either party. The effective date shall be the date the agreement is signed by TMA

This agreement may be terminated by either party by giving the other party written notice of termination. The provider shall also provide written notice to the public. Such notice of termination is to be received by the other party no later than 45 days prior to the date of termination. In the event of transfer of ownership, this agreement is assigned to the new owner, subject to the conditions specified in this agreement and pertinent regulations.

FOR PROVIDER OF SERVICES BY:		FOR TMA BY:	
____________________		____________________	
Name		Name	
____________________		____________________	
Title	Date	Title	Date

\- END -