CORPORATE SERVICES PROVIDER
APPLICATION FOR TRICARE PROVIDER STATUS

OMB No. 0720-0020
OMB approval expires

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 INQUIRIES, PLEASE CALL: [Contractor's provider-inquiry telephone number]

1. PROVIDER NAME

2. PROVIDER CERTIFICATION *(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.

a. SIGNATURE OF CHIEF EXECUTIVE OFFICER	b. DATE *(YYYYMMDD)*

3. INSTITUTION/CORPORATE SERVICES PROVIDER IDENTIFICATION INFORMATION

a. NAME

b. CORPORATE/FOUNDATION NAME *(If different)*

c. ADDRESS *(Physical location) (Street, City, State and ZIP Code)*	d. MAILING ADDRESS *(If different)*
N E E D S	D D 6 7

e. TELEPHONE NUMBER *(Include Area Code)*	f. FACSIMILE NUMBER *(Include Area Code)*	g. TAX ID NUMBER

h. ARE YOU A MEDICARE PROVIDER? ☐ YES ☐ NO *(If Yes:)*

(1) MEDICARE CERTIFICATION NUMBER	(2) MEDICARE CATEGORY	(3) MEDICARE ACCEPTANCE DATE *(YYYYMMDD)*

i. ARE YOU A JCAHO ACCREDITED? ☐ YES ☐ NO *(If Yes:)*

(1) JCAHO CLASSIFICATION	(2) ORIGINAL JCAHO CLASSIFICATION DATE *(YYYYMMDD)*	(3) CURRENT JCAHO CLASSIFICATION DATES *(YYYYMMDD)* FROM: TO:

j. STATE LICENSE CLASSIFICATION	k. DATES OF STATE LICENSURE *(YYYYMMDD)* FROM: TO:

l. ARE YOU CERTIFIED BY A NATIONAL BOARD? ☐ YES ☐ NO *(If Yes:)*

(1) NAME OF BOARD	(2) EFFECTIVE DATE OF CERTIFICATION *(YYYYMMDD)*

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