Autism Services Demonstration Certification

Dear Provider, Date of Application ____/______/______

To become an authorized TRICARE provider or update your certification, please complete and return all applicable forms within thirty (30) days. Services should not be provided to TRICARE beneficiaries until you have received notification from TriWest that you meet the Demonstration Project criteria. Any services provided to TRICARE beneficiaries prior to your approval will result in denial of your claims.

Complete the enclosed forms (if applicable)

1. Clinic or Group Application.

2. Individual Application Forms that apply.

3. Attach copies of applicable documentation:
   - ❒ Copy of current unexpired state license, if applicable
   - ❒ Copy of Behavior Analyst Certification Board certificate (if board certified)
   - ❒ Copy of current unexpired malpractice declaration sheet, minimum of $1 million per claim/$3 million in aggregate required, unless there are different state requirements (evidence of professional liability insurance which indicates coverage limits and expiration dates)
   - ❒ Current resume / Curriculum Vitae (use month and year to indicate time for education, training and work history)

4. Signatures: (check one of the following options)
   - ❒ Your staff may sign TRICARE claim forms on your behalf when the necessary Authorized Signer form has been completed.
   - ❒ Computer Generated Facsimile or Rubber Stamp Authorization may also be used when the necessary agreement is on file. Computer generated "Signature on file" is not acceptable.
   - ❒ An original signature by the individual provider.

5. Complete W-9.

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

Thank you for your cooperation and prompt response.

Sincerely,

TriWest Credentialing Department

Please return to: TriWest Healthcare Alliance
Attn: Provider Services
P.O. Box 42049
Phoenix, AZ 85080

TO BE USED FOR THE AUTISM SERVICES DEMONSTRATION ONLY

PERSONAL INFORMATION			
PROVIDER'S NAME (Last Name, First Name, MI, Degree)	MAIDEN NAME (If Applicable)	SOCIAL SECURITY NUMBER	
DATE OF BIRTH (mm/dd/yy)	GENDER ❒ M ❒ F	PLACE OF BIRTH (City, State, Country)	FOREIGN LANGUAGES ❒ Speak ❒ Read ❒ Write
MEDICARE #: UPIN #:	Individual NPI #: Group NPI #:	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

PRACTICE/OFFICE INFORMATION					
Practice/Group Name:					Federal Tax ID#:
Office Location (Street Address):			Billing Address (if different):		
City:	State:	Zip:	City:	State:	Zip:
Office Phone: ( )	Office Fax: ( )		Billing Phone: ( )	Billing Fax: ( )	
Additional Practice Location (use a separate sheet to submit additional practice locations)					
Office Location (Street Address):			Billing Address (if different):		
Office Phone: ( )	Office Fax: ( )		Billing Phone: ( )	Billing Fax: ( )	
City:	State:	Zip:	City:	State:	Zip:
Provides remote supervision ❒ Yes ❒ No					

EDUCATION AND TRAINING			
Have you earned a degree from an accredited education institution? ❒ Yes ❒ No If yes, please complete this section.			
Name of School/Institution:	Address, City, State, Zip:	Year Earned:	Degree Earned:

SPECIALTY LIST ALL SPECIALTIES PRACTICED, BEGIN WITH PRIMARY SPECIALTY
Primary:
Secondary:

STATE LICENSE/CERTIFICATION INFORMATION **Please list all Current and Previous Licenses or State Certifications in all jurisdictions.** (Attach a copy of all licenses/certificates)					
State of Issue	Number	Current	Original Issue Date	Current Issue Date	Expiration Date
		❒ Yes ❒ No			
		❒ Yes ❒ No			

Educational Interventions for Autism (EIA) Supervisor Certification Requirements
Please attest to one of the requirements listed below and provide any requested documentation.

- Evidence of Professional Liability Insurance in the amounts of $1 million per claim and $3 million in aggregate; **please attach a copy of your malpractice certificate**.

❒ I verify that I have a current, unrestricted State-issued license to provide ABA services (submit copy); **OR**

❒ I verify that I have a current, unrestricted State-issued certificate as a provider of ABA services (submit copy); **OR**

❒ I verify am certified by the BACB (http://www.bacb.com) as either a BCBA or a BCABA where such state-issued license or certification is not available;

AND

❒ I verify that I employ directly or contract with EIA Tutors.

AND

❒ I verify that all applicable business licenses and employment or contractual documentation are maintained in accordance with Federal, State, and local requirements.

____ ________________________
Signature Date

Educational Interventions for Autism (EIA) Tutors Certification Requirements
Please include detailed information for any Tutors in which you supervise.

The qualifications for EIA Tutors are outlined below. Use this information as a guideline and verify that each tutor in which you supervise meets these qualifications:

- Completed 40 hours of classroom training in ABA techniques in accordance with the BACB Guidelines for Responsible Conduct for Behavior Analysts (http://www.bacb.com),

  AND

- Undergone a criminal background check;

  AND

- Complete a minimum of 12 semester hours of college coursework in psychology, education, social work, behavioral sciences, human development or related fields and be currently enrolled in a course of study leading to an associate's or bachelor's degree by an accredited college or university; **OR**
- Completed a minimum of 48 semester hours of college courses in an accredited college or university; **OR**
- A High School diploma or GED equivalent and have completed 500 hours of employment providing ABA services as verified by the ACSP;

  AND

- Receives no less than two hours supervision per month from the EIA Supervisor, in accordance with the BACB Guidelines for Responsible Conduct for Behavior Analysts.

EIA Tutor(s) Training Checklist and Attestation

Must be completed for all Tutors. Supporting documentation for all information (i.e. resume/curriculum vitae, transcripts, letters from educational institutions or supervisors) must be included with this application.

Please provide physical address information for each tutor if different than Supervisor as listed on page 2 under Office/Practice Information.

Name	Gender	40 hrs classroom training completed Yes / No	Educ reqmts completed Yes / No	Receives 2 hrs min. supervision per month Yes / No	CHBC Completed Yes / No	Meets Reqmts Yes / No

❒ By signing below, I certify that the EIA Tutors identified above meet the certification requirements as outlined in TRICARE Operations Manual Chapter 20, Section 10 and on page 3 and meet the minimum evidence-based standards as indicated by the current BACB Task List, the BACB Professional Disciplinary Standards, the BACB Guidelines for Responsible Conduct for Behavior Analysts, and current BACB rules and regulations.

______________________________ Signature

______________________________ Date

QUESTIONNAIRE/PERSONAL STATEMENTS

If you answer yes to any of the following questions, a complete detailed written explanation is required, if any question does not apply write N/A and a complete detailed written explanation is required

	Criminal History		
1	Have you ever been convicted of a felony, fraud, narcotics offense, moral, or any other type of ethical crime?	Yes	No
2	Have you ever been convicted of a misdemeanor case?	Yes	No
	Certification History		
1	Has your BACB certification ever been sanctioned, limited, restricted, revoked, suspended, voluntarily relinquished, terminated, subjected to disciplinary action or otherwise acted upon in an adverse manner?	Yes	No

Please provide a detailed statement for any question in which you answered yes above. Attach additional documentation if necessary. Please note: any action issued by the BACB for violation of published disciplinary standards must be reported to TriWest within 30 days.

CONFLICT OF INTEREST STATEMENT

For TRICARE providers:
Federal law (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.

CERTIFICATION/ATTESTATION

I, ____hereby 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.

____ ___________________________

Signature Date

CONSENT TO THE INSPECTION OF RECORDS AND DOCUMENTS
RELEASE OF INFORMATION AND LIABILITY

I, ____hereby 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.

____ ___________________________

Signature Date

COMPLIANCE WITH TRICARE ELIGIBILITY AND
AUTISM DEMONSTRATION PROGRAM REQUIREMENTS

I, ____hereby certify and attest that I and all tutors that I supervise have read and understand the TRICARE Eligibility and Autism Demonstration Program requirements as outlined in TRICARE Operations Manual Chapter 20, Section 10 and meet education, training, experience, competency, supervision and demonstration requirements.

____ ___________________________

Signature Date

INSERT DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE
FORM W-9