16010 North 28th Avenue
Phoenix, Arizona 85053
Main: 1-888-TRIWEST (874-9378)

www.triwest.com

TriWest Healthcare Alliance Corp. would like to take this opportunity to thank you for your desire to care for TRICARE beneficiaries. Providing quality health care helps ensure that active duty service members, military retirees and their family members are well served. Deployed service members especially take great comfort knowing their family members' health care is secure.

TriWest has made accessing information about the TRICARE program o www.triwest.com/provider easy and convenient for you and your business office staff. Once registration is authenticated, you have direct access to the secure provider portal, allowing you to:

- Verify patient eligibility
- Submit referrals/authorizations online
- Determine status of referrals/authorizations
- Submit claims online
- View claims and check claim status
- Download Explanations of Benefits

In addition, www.triwest.com/provider has several resources located to help you find information regarding TRICARE reimbursement rates, referrals and authorizations, claims and reimbursement, TRICARE programs and benefits, Electronic Data Interchange (EDI), the Resource Library, and more!

Here are some other sources that are designed to assist you in providing care to beneficiaries:

- The ***Interactive Voice Response (IVR) system*** is available 24-7 by calling 1-888-TRIWEST (874-9378). An IVR Tips Guide is available in the Resource Library at www.triwest.com/provider to guide you through the process.
- **TRICARE Field Representative (TFR)** You may call 1-888-TRIWEST (874-9378) to request the assistance of your local TFR if you need assistance with the TRICARE certification process or if you require education regarding TRICARE.
- ***TriWest's eSeminars*** offer the convenience of learning about TRICARE programs in the comfort of your office, home or any location with Internet access at a time most convenient to you. Go to www.triwest.com/provider to take an eSeminar.
- ***Filing Claims: Electronic Data Interchange (EDI)*** Wisconsin Physicians Service (WPS) staff is skilled in implementing EDI strategies with a variety of provider specialties, billing services, and software vendors. Choosing one of their electronic data interchange (EDI) options assures you ample assistance throughout the claims filing process. The EDI edit systems are designed to minimize data entry errors before claims are passed to the WPS processing system. EDI claims are generally processed and paid very quickly.

Thank you again for your interest in providing care to TRICARE beneficiaries in the West Region. For additional information on registering for the secure provider portal, submitting your claims online and signing up to receive ERA, refer to www.triwest.com/provider, or call 1-800-782-2680 (EDI Help Desk).

Lisa D Stevens

Vice President, Provider Services
TriWest Healthcare Alliance

# CERTIFIED PSYCHIATRIC NURSE SPECIALIST
# PROVIDER FILE APPLICATION

Date of Request ___/__ /___

Name ________________________________________ Telephone # (___ ) ____________

National Provider Identifier (NPI) # ____________________ Federal Tax ID # ______________

Medicare # ____________________________________

**Office Location** (Street Address): ________________________________________

________________________________________

________________________________________

**Billing Address** (If Different): ________________________________________

________________________________________

________________________________________

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

If Yes:

Group Name ____________________________________________________________

You must complete the Special Authorization form if the group will bill on your behalf.
Date you began filing with group #:___ /__ /____

Do you maintain a solo practice: ❑Yes ❑ No

| **Are you:** | | **Location** |
|---|---|---|
| Hospital employed or contracted? | ❑ Yes ❑No | ____________________ |
| Teaching-setting? | ❑ Yes ❑No | ____________________ |
| Employed by the U.S. Government? | ❑ Yes ❑No | ____________________ |

LICENSE #____________________________________ ❑ Temporary

❑ Permanent Issuing State ______________

Date license was first issued______ /____ /_____ Exp. Date ____ /____ /_____

**Enclose copy of licensure/certification.**

Regulations require that a certified psychiatric nurse specialist may provide covered services independent of physician referral and supervision. For purposes of TRICARE, a certified nurse specialist is an individual who:

- Is a licensed, registered nurse
- Has at least a master's degree in nursing with a specialization in psychiatric and mental health nursing
- Has at least two years of post-Master's Degree practice in the field of psychiatric and mental health nursing, including an average of eight hours of direct patient contact per week **OR** is certified by the American Nurses Association through the American Nurses Credentialing Center.

## DEGREE INFORMATION

Name of Degree ______________________________

Name of School ______________________________

Indicate field of specialization ______________________________

After receiving my master's degree, I have had at least 2 years of practice in the field of psychiatric and mental health nursing including an average of eight hours of direct patient contact per week. ❑Yes ❑ No

I am certified by the American Nurses Association. ❑Yes ❑ No

You must include copies of your state or national licensure certificates, college transcripts and a resume of your supervised experience. This is required by TRICARE to approve your certification as an authorized TRICARE provider.

If you do not meet the above qualifications, you may be eligible as a Registered Nurse only to provide Medical Services not in the psychiatric area of care. You must meet all qualifications to provide Psychiatric services to patients.

I certify that the above information is true and correct to the best of my knowledge.

Signature ______________________________ Date ______________

## 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.

Please return to:

WPS TRICARE Provider Certification
P.O. Box 8730
Madison, WI 53708-8730

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

# 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, and Signature** | **Specialty and Social Security Number** | **State License Number if Required or Organization** |
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## AUTHORIZED SIGNER

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.

Hospital/Clinic Name:_______________________________ Hospital/Clinic IRS Tax Number:____________________

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 cancelled 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 are as follows:

______________________________________________________________________________

Signature | Printed Name | Official Title

______________________________________________________________________________

Signature | Printed Name | Official Title

______________________________________________________________________________

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

______________________________________________________________________________

### COMPUTER GENERATED FACSIMILE OR RUBBER STAMP AUTHORIZATION

Name: ______________________________ NPI #: _______________________ IRS Tax#:____________________

Address:________________________________________ City, State, Zip:__________________________________

__________________________being first duly sworn, deposes and says: I hereby authorize Wisconsin Physicians Service Insurance Corporation 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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