



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 on 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).

A handwritten signature in black ink that reads "Lisa Stevens". The signature is written in a cursive, flowing style.

Vice President, Provider Services
TriWest Healthcare Alliance

CLINICAL PSYCHOLOGIST 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 physician? Yes No _____

Teaching-setting physician? Yes No _____

Employed by the U.S. Government? Yes No _____

LICENSE # _____ Temporary
 Permanent Issuing State _____

Date license was first issued ____ / ____ / ____ Expiration Date ____ / ____ / ____

Enclose copy of licensure/certification.

Regulations require that all clinical psychologists dealing with TRICARE beneficiaries on a fee-for-service basis must:

- a. Be licensed or certified by the state for the independent practice of psychology and
- b. Possess a doctoral degree (Ph.D. or Psy.D.) in psychology from a regionally accredited university and
- c. In addition have had two years of supervised clinical experience in psychological health services of which at least one year is post-doctoral and one year (may be post-doctoral year) in an organized psychological health service training program
- d. Or as an alternative to b. + c. above, be listed in the National Register of Health Service Providers in Psychology, published by the Council for the National Register of Health Service Providers on Psychology.

DOCTORATE

Name of School _____ City _____ State _____

Name of Degree _____ Year earned _____

Indicate field in which doctorate was earned _____

CLINICAL EXPERIENCE

I have two years of supervised clinic experience in psychological health services of which at least one year is post-doctoral and one year (may be the post-doctoral year) in an organized psychological health service training program;

INTERNSHIP IN CLINICAL PSYCHOLOGY

Name of Institution _____

City and State _____ From _____ To _____

INTERNSHIP IN CLINICAL PSYCHOLOGY

Name of Institution(s) _____

City and State _____ From _____ To _____

I am listed in the National Register of Health Service Providers in Psychology, published by the Council for the National Register of Health Service Providers in Psychology. Yes No

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.).

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)