



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 style.

Vice President, Provider Services
TriWest Healthcare Alliance

TRICARE West Region
"Whatever It Takes"

MENTAL HEALTH COUNSELORS PROVIDER FILE APPLICATION

Date of Request ____ / ____ / ____

Name _____

Telephone # (____) _____

National Provider Identifier (NPI) # _____

Federal Tax ID # _____

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 based? Yes No _____

Teaching-setting? Yes No _____

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

LICENSE # _____ Temporary

Date license was first issued ____ / ____ / ____ Permanent Issuing State _____

Expiration Date ____ / ____ / ____ Medicare # _____

Enclose copy of licensure/certification.

The services of certain Mental Health Counselors are covered on a fee-for-service basis if the beneficiary is referred by a physician and the physician is providing on-going oversight and supervision of the services being provided.

The provider must possess a valid state license or certificate as a Mental Health Counselor or hold a license or certificate that allows the individual to provide Mental Health counseling in states which require such licensing or certification,

OR

In jurisdictions that do not offer licensure as a Mental Health Counselor, the provider must be eligible for full clinical membership in the American Mental Health Counselor Association (AMHCA); or, be certified (or eligible for certification) as a Certified Clinical Mental Health Counselor (CCMHC) by the Clinical Academy of the National Board of Certified Counselors (NBCC).

Information regarding the AMHCA may be found at www.amhca.org or by calling 800-326-2642.

Information regarding the NBCC may be found at www.nbcc.org or by calling 336-547-0607.

I am licensed or certified as a _____

by the state of _____

I certify that I am currently a Member or a Fellow of the National Academy of Certified Clinical Mental Health Counselors.

Yes _____ No _____ Eligible _____

In addition, Mental Health Counselors must have a recognized graduate professional education consisting of a Master's Degree in Mental Health Counseling or allied mental health field from a regionally accredited institution:

Name and Location of School: _____

Degree Earned _____ Year Earned _____

Field of Study _____

The following experience requirements must also be met:

Two years of post-master's experience which includes 3,000 hours of Clinical work and 100 hours of face-to-face supervision.

I certify that I have completed the number of hours of practice required: Yes _____ No _____

Signature _____

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)