HEALTH NET FEDERAL SERVICES
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TRICARE®

Request to Participate as a Network Applied Behavior Analysis Provider in the TRICARE West Region

Thank you for your interest in partnering with Health Net Federal Services, LLC (HNFS) as an applied behavior analysis (ABA) provider in the Autism Care Demonstration (ACD).

Before you begin filling out the *Applied Behavior Analysis Provider Demographics Form* (located on page 2), please review the requirements detailed on this page and complete the *Affirmation of Provider Eligibility* (located on page 3).

Note: ACD information and requirements also can be reviewed at **www.tricare-west.com/go/ACD-provider**.

ABA Provider Types Subject to Credentialing

- Board Certified Behavior Analyst® (BCBA®)
- Board Certified Behavior Analyst® – Doctoral (BCBA-D®)
- Board Certified Assistant Behavior Analyst® (BCaBA®)
- Qualified Autism Services Practitioner - Supervisor (QASP-S®)
- Licensed behavior analyst (LBA)
- Licensed assistant behavior analyst (LaBA)

ABA Provider Types Subject to Certification

- Registered Behavior Technician® (RBT®)
- Applied Behavior Analysis Technician (ABAT®)
- Board Certified Autism Technician (BCAT)

Mandatory Requirements for All ABA Provider Types

Important: Do not submit the materials listed in this section with your *Affirmation of Provider Eligibility*. You will submit the materials in this section when you submit your completed *Provider Participation Agreement/Packet*.

- Include copies of criminal history background checks (CHBCs) to HNFS. CHBCs must include:
  – Current federal, state and county criminal and sex offender reports.
  – All locations in which you have resided or worked during the previous 10 years.
- Have a National Provider Identifier (NPI).
- Provide basic life support (BLS) and cardiopulmonary resuscitation (CPR) certification to HNFS. Accepted BLS/CPR certification classes include:
  – In-person courses (100%), or
  – Hybrid in-person and online courses.

Important: Certifications from classes that are 100% online/without any in-person training **will not** be accepted.

- Use the *Network TRICARE Provider Roster* template for all roster submissions and updates. The template is available at **www.tricare-west.com** > *Provider* > *Resources* > *Forms* > *Network Providers* > *Network TRICARE Provider Roster*.
- Complete ACD annual training requirements (applies to Autism Corporate Services Providers [ACSP] and sole ABA providers).
- Provide HNFS with proof of current professional liability insurance in the amounts of one million dollars per claim and three million in aggregate. Professional liability insurance must also be maintained in an ACSP's/sole ABA provider's name.
- Enroll in electronic funds transfer (EFT) for claims reimbursement (applies to ACSPs and sole ABA providers).

Note: You will submit your completed *Applied Behavior Analysis Provider Demographics Form* (page 2) and *Affirmation of Provider Eligibility* (page 3) as email attachments to **ACDNetwork@hnfs.com**.

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ABA Provider Demographics Form

General Information

1. Select the contract type.
   - ☐ ABA services only
   - ☐ ABA and mental health services
   - ☐ ABA and physical health services
   - ☐ ABA, mental health and physical health services

2. Choose your ABA provider type.
   - ☐ Sole ABA provider
   - ☐ ACSP – How many ABA providers are in your group? ______________________

3. Select the TRICARE West Region state(s) in which you have an active license to practice.
   - ☐ Alaska
   - ☐ Arizona
   - ☐ California
   - ☐ Colorado
   - ☐ Hawaii
   - ☐ Idaho
   - ☐ Iowa (except Rock Island Arsenal area)
   - ☐ Kansas
   - ☐ Minnesota
   - ☐ Missouri (except St. Louis area)
   - ☐ Montana
   - ☐ Nebraska
   - ☐ Nevada
   - ☐ New Mexico
   - ☐ North Dakota
   - ☐ Oregon
   - ☐ South Dakota
   - ☐ Texas (Amarillo, Lubbock and El Paso areas only)
   - ☐ Utah
   - ☐ Washington
   - ☐ Wyoming

Practice Information

1. Practice/Doing Business As (DBA) Name: ______________________
2. Practice/DBA Physical Address (Street address, Suite/No.; City, State, ZIP code): ______________________
3. Point-of-Contact (POC) Business Title: ______________________
4. POC Email Address: ______________________
5. POC Phone Number: ______________________

Provider Identification Numbers

1. Tax Identification Number (TIN): ______________________
2. National Provider Identifier (NPI) Number (Practice Owner): ______________________
3. NPI Number (Organization/Location): ______________________

Credentialing Information

1. POC Name: ______________________
2. POC Phone: ______________________
3. POC Fax: ______________________
4. POC Email: ______________________

Legal Information

1. Legal Notice POC Name (Person signing contract): ______________________
2. Legal Notice POC Address: (Street address, Suite/No.; City, State, ZIP code): ______________________
3. Legal Notice POC Phone: ______________________
4. Legal Notice POC Fax: ______________________
5. Legal Notice POC Email: ______________________

Business Owner Information

1. Business Owner Name: ______________________
2. Business Owner Phone: ______________________
3. Business Owner Email: ______________________

Affirmation of Provider Eligibility

Submit your completed A*ffirmation of Provider Eligibility* (below) and *ABA Provider Demographics Form (located on page 2)* as email attachments to **ACDNetwork@hnfs.com**.

Important: Please use the subject line "*ABA Provider Demographics Form* and *Affirmation of Provider Eligibility*" in your email to HNFS and keep copies of your completed *ABA Provider Demographics Form* and *Affirmation of Provider Eligibility* for your records.

Upon review, HNFS will contact you to let you know your eligibility status and any next steps.

Affirmation of Provider Eligibility

☐ By checking this box, I agree that I understand and affirm that I meet the ACD program requirements and can provide the materials listed on page 1 with my completed *Provider Participation Agreement/Packet*; and, if I am determined eligible to participate in the ACD, I agree to complete ACD annual training.

First and Last Name (Printed): ____________________

Signature: ____________________

Date *Affirmation of Provider Eligibility* Signed: __________

Note: You must submit your completed *ABA Provider Demographics Form (page 2)* and signed *Affirmation of Provider Eligibility* as attachments in an email to **ACDNetwork@hnfs.com**.

You also can email **ACDNetwork@hnfs.com** with any questions you have concerning any part of this *Request to Participate as a Network Applied Behavior Analysis Provider in the TRICARE West Region* form.