TRICARE NON-NETWORK PROVIDER APPLICATION

LACTATION CONSULTANT (LC)
CERTIFIED LACTATION COUNSELOR (CLC)
CERTIFIED LABOR DOULA (CLD)

Please submit the completed application package to:

Fax: 844-730-1373

or

Mail to:

TRICARE West

Provider Data Management

PO Box 202106

Florence, SC 29502-2106

Health Net Federal Services offers payments and remittances by National Provider Identifier (NPI) number. ***The NPI billed on the claim will determine where payment and remittance will be sent.*** *It is critical the information provided matches how your office will file claims. Inconsistent data will negatively impact claims payment.*

If your business requires multiple mailing/payment addresses, please provide an NPI for each. ***If you have more than one NPI, you must complete a separate application for each NPI number.***

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TRICARE Non-Network Individual Application

First Name: ____________________________ MI: ____ Last Name: _______________________________

Gen: _______ Title: ____

Social Security #: _______________________________ NPI#: __________________________________

Are you employed by the US Government? ____ Yes ____ No

Do you sign your own claim forms? ____ Yes ____ No

If No, Signature Authorization forms are attached. Please complete these forms and have them notarized for each practitioner. Without signature authorization forms on file, each claim will require a physical signature from the rendering provider and claims without signature will be returned without processing the claim for payment.

Do you maintain a solo practice? ____ Yes ____ No

Solo Practice Information

Solo Practice Tax ID: __________________________ NPI#: ___________________________________

Date you began using this Tax ID #: (mm/dd/yyyy) ________________

Solo Physical Address (Street Address):

____

____

____

Solo Billing Address for this NPI:

____

____

____

Telephone #: ____________________________ Billing Telephone #: _______________________

Fax #: ___________________________________ Email: ___________________________________

Do you work with an established group practice or institution? ____ Yes ____ No

Group Practice Information

If you practice at multiple locations, please provide the information below for each location.

Group Practice Name: ____________________________

Group Practice Tax ID #: ___________________________ NPI#: _______________________________

Effective date of the group's Tax ID number or EIN (Date legal entity established): ________________ (mm/dd/yyyy)

Date you began practicing with this group number: ________________ (mm/dd/yyyy)

Group Physical Address (Street Address):

____

____

____

Group Billing Address for this NPI:

____

____

____

Telephone #: ____________________________ Billing Telephone #: _______________________

Fax #: ___________________________________ Email: ___________________________________

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To certify you as a **Lactation Consultant / Certified Lactation Counselor,** please provide the following information to confirm you meet TRICARE requirements. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

18 Years of Age: _____Yes _____No

Licensure, if offered by state:

License Number: ________________________________

Original License Issue Date: ______________ Expiration Date: ______________

Are you licensed as an RN? _____Yes _____No

RN License Number: ________________________________

Original License Issue Date: ______________ Expiration Date: ______________

****Attach a copy of State license***

Certification: (Select applicable certification)

_____ International Board of Lactation Consult Examiners (IBCLC) as a Certification Lactation Consultant

_____ Academy of Lactation Policy and Practice, Inc. (ALPP) as an Advanced Lactation Consultant or an Advanced Nurse Lactation Consultant

_____ Academy of Lactation Policy and Practice, Inc. (ALPP) as a Certified Lactation Counselor

Certification Number: ______________________________________

Original Issue Date: ______________ Expiration Date: ______________
(mm/dd/yyyy) (mm/dd/yyyy)

****Attach a copy of certification***

CPR: Must have a current adult, child and infant Cardiopulmonary Resuscitation (CPR) certification

Date Complete: ___________________ ****Attach a copy of certification***
(mm/dd/yyyy)

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: ____ Date: _______________

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To certify you as a **Certified Labor Doula,** please provide the following information to confirm you meet TRICARE requirements. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

18 Years of Age: _____Yes _____No

Licensure, if offered by state: ***Attach a copy of State license**

License Number: ___________________________________

Original License Issue Date: ______________ Current Expiration Date: ______________

Education: Has attended a minimum of 24 education hours remote synchronous or asynchronous online courses or in-person courses to include:

- The physiology of labor
- Labor doula training
- Antepartum doula training
- Postpartum doula training
- Attended one or more breastfeeding courses
- Attended one or more childbirth classes

Experience: Within the last three years:

- Provided continuous in-person childbirth support for at least three childbirths as the primary labor doula supporting the birthing parent, with a minimum of 15 hours over the three childbirths
- At least two of the three births were a vaginal birth
- Provided antepartum and postpartum support for at least one birth

NOTE: *Certified Labor Doula (CLD) education and experience components cannot be obtained during CLD's own childbirth or the childbirth of an immediate family member*

Certification: Holds a current certification obtained within the last three years from one of the following organizations: ***Attach a copy of certification***

___ BirthWorks International
___ Childbirth and Postpartum Professional Association
___ Doulas of North America (DONA) International
___ International Childbirth Education Association
___ ToLABOR

Certification Number: ___________________________________

Original Certification Issue Date: ______________ Certification Expiration Date: ______________
(mm/dd/yyyy) (mm/dd/yyyy)

CPR: Must have a current adult, child and infant Cardiopulmonary Resuscitation (CPR) certification
Date Complete: __________________ ***Attach a copy of certification***
(mm/dd/yyyy)

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious, or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

Practitioner Signature: ____ Date: _______________

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PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

State of ___________________________

County of __________________________

_____________________________________ being first duly sworn, deposes and says: I hereby authorize PGBA, LLC / Health Net Federal Services in the state of South Carolina to accept my facsimile or stamp signature shown below.

(Facsimile, stamp or computer generated signature as it will appear on the claim form.)

as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the TRICARE payment system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

____

Signature

Subscribed and sworn to before me this ____________ day of _______________ 20____.

____

Notary Public in and for

________________ County, State of _____________________

(SEAL)

My Commission expires ____

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PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

State of ___________________________

County of __________________________

Know all persons by these presents:

That I, ______________________________ have made, constituted and appointed and by these presents do make constitute and appoint ______________________________ my true and lawful attorney-in-fact for me and in my name place and stead to sign my name on claims, for payment for services provided by me submitted to TRICARE. My signature by my said attorney-in-fact includes my agreement to abide by the TRICARE payment system concept and the remainder of the certification appearing on all TRICARE claim forms. I hereby ratify and confirm all that my said attorney-in-fact shall lawfully do or cause to be done by virtue of the power granted herein.

In witness whereof I have hereunto set my hand this ________day of _______________ 20___.

____
Signature

Subscribed and sworn to before me this ____________ day of _______________ 20____.

____
Notary Public in and for

________________ County, State of _____________________

(SEAL)

My Commission expires _____________________________

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