TRICARE NON-NETWORK MENTAL HEALTH COUNSELOR (SMHC/TCMHC) PROVIDER APPLICATION

*We expect providers to submit claims electronically. If it is necessary to submit a paper claim, the only acceptable forms are the approved **red and white** NUCC 1500 (02-12) form and the NUBC UB-04 (CMS -1450) forms. These forms must include the instructions on the back page.*

There are two types of Mental Health Counselors in the TRICARE Program.

Supervised Mental Health Counselor (SMHC): requires oversight by a physician.

and

TRICARE Certified Mental Health Counselor (TCMHC): an independent provider who does not require referral and oversight by a physician.

Please carefully review and complete the enclosed application to determine if you meet TRICARE requirements to be a SMHC or TCMHC. If you do not meet TRICARE Requirements to be a TCMHC, you may still qualify to be a Supervised Mental Health Counselor.

Please submit the completed application package to:

Fax: 877-989-0066
or

Mail to:
TRICARE West
Provider Data Management
PO Box 202169
Florence, SC 29502-2169

*TriWest Healthcare Alliance 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 Mental Health Counselor 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):

_____

_____

_____

Telephone #: _____

Fax #: _____

Solo Billing Address for this NPI:

_____

_____

_____

Billing Telephone #: _____

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):

_____

_____

_____

Telephone #: _____

Fax #: _____

Group Billing Address for this NPI:

_____

_____

_____

Billing Telephone #: _____

Email: _____

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SUPERVISED MENTAL HEALTH COUNSELOR (SMHC)

To certify you as a **Supervised Mental Health Counselor (SMHC)**, please provide the following information to confirm you meet TRICARE requirements. In the TRICARE program, a SMHC requires oversight by a physician. A Licensed Psychological Associate may provide services in the TRICARE program as a SMHC as long as they meet the requirements listed below. 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.

Licensure: *licensed to practice as a mental health counselor by the jurisdiction where practicing*

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Education: *has a master's or higher-level degree in mental health counseling or allied mental health field from a regionally accredited institution*

Date Graduated: _____ Degree Earned/Program: _____
(mm/yyyy)

Name of University: _____

Clinical Experience: *Has completed two years of post-master's experience which includes 3,000 hours of clinical work and 100 hours of face-to-face supervision.*

_____ Yes _____ No Date Experience Requirements Met: _____
(mm/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 Name (please print): _____ Date: _____

Practitioner Signature: _____

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TRICARE CERTIFIED MENTAL HEALTH COUNSELOR (TCMHC)

To certify you as a **TRICARE Certified Mental Health Counselor (TCMHC)**, please provide the following information to confirm you meet TRICARE requirements. In the TRICARE program, A TCMHC does not require referral and oversight by a physician. 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.

Licensure: *licensed for independent practice in mental health counseling by the jurisdiction where practicing*

License Number: _____

Original License Date: _____ Current Expiration Date: _____

Education: *has a master's or higher-level degree from a mental health counseling program of education and training accredited for Mental Health Counseling or Clinical Mental Health.*

Date Graduated: (mm/yyyy) _____ Degree Earned/Program: _____

Name of University: _____

Please select the accreditation program your college/university is accredited by:

____ Council for Accreditation of Counseling and Related Education Programs (CACREP)

____ Council for Higher Education Accreditation (CHEA)*

____ US Department of Education (USDE)

____ Accrediting Commission for Community and Junior College Western, Association of Schools and Colleges (ACCJC-WASC)

____ Higher Learner Commission (HLC)

____ Middle States Commission on Higher Education (MSCHE)

____ New England Association of Schools and Colleges Commission on Institutions of Higher Education (NEASC-CIHE)

____ Southern Association of Colleges and Schools (SACS) Commission on Colleges

____ WASC Senior College and University Commission (WASC-SCUC)

____ Accrediting Bureau of Health Education Schools (ABHES)

____ Accrediting Commission of Career Schools and Colleges (ACCSC)

____ Accrediting Council for Independent Colleges and Schools (ACICS)

____ Distance Education Accreditation Commission (DEAC)

*Note- if your school is accredited by the Council for Higher Education Accreditation, you must have passed the National Clinical Health Counselor Examination (NCMHCE) to meet TRICARE requirements as a TCMHC.

Exam: *Has passed the* ***National Clinical Mental Health Counselor Examination (NCMHCE)*** *or the* ***National Counselor Examination (NCE)*.***

Please specify which examination:

____ National Clinical Mental Health Counselor Examination (NCMHCE)

____ National Counselor Examination (NCE)* ***must have passed the NCE prior to January 1, 2017.***

Date passed: (mm/dd/yyyy) _____

Clinical Experience: *has a minimum of two years of post-master's degree supervised mental health counseling practice that includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision. This supervision must be provided by mental health counselors, psychiatrists, clinical psychologists, Certified Clinical Social Workers (CCSWs), TCMHCs, or Certified Psychiatric Nurse Specialists (CPNSs) who are licensed for independent practice in the jurisdiction where practicing and must be practicing within the scope of their licenses. Supervision must be conducted in a manner that is consistent with the guidelines regarding knowledge, skills, and practice standards for supervision of the American Mental Health Counselors Association (AMHCA)*

_____ Yes _____ No Date Experience Requirements Met: _____

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 Name (please print): _____ Date: _____

Practitioner Signature: _____

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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 / TriWest Healthcare Alliance 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 _____

Revised: 1/7/2025

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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