TRICARE NON-NETWORK PASTORAL COUNSELOR 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.*

In the TRICARE program, the services of an authorized Pastoral Counselor are covered when:

- A physician refers the beneficiary for therapy
- A physician provides ongoing oversight and supervision of the therapy
- On each claim, the pastoral counselor certifies that a written communication has been (or will be) made to the referring physician of the results of the treatment.

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

Note: Due to the similarity of the requirements for licensure, certification, experience and education a pastoral counselor may elect to be authorized as a certified marriage and family therapist. If you are interested in becoming a Certified Marriage and Family Therapist, please complete the Certified Marriage and Family Therapist individual application. No dual status will be recognized.

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 Pastoral 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):

____

____

____

Solo Billing Address for this NPI:

____

____

____

Telephone #: ____________________________

Fax #: __________________________________

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):

____

____

____

Group Billing Address for this NPI:

____

____

____

Telephone #: ____________________________

Fax #: __________________________________

Billing Telephone #: _______________________

Email: __________________________________

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To certify you as a **Pastoral 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.

Licensure: *If licensure/certification as a pastoral counselor is offered by the jurisdiction in which the provider is practicing, it is required in all cases, even if the jurisdiction offers it on an optional basis.*

License/Certification Number: ___________________________________

Original License/Certification Date: ______________ Current Expiration Date: ______________

Prior to March 1, 2019, in jurisdictions that **do not offer specific licensure or certification for pastoral counselors, the provider must be certified or be eligible for fellow or diplomate membership in the American Association of Pastoral Counselors (AAPC). If a provider is eligible for membership in the AAPC but is not a member, he/she **must submit documentation** obtained from the AAPC of such eligibility.*

**Beginning March 1, 2019, in jurisdictions that do not offer licensure or certification, a pastoral counselor must be (or meet all requirements to become) an Association for Clinical Pastoral Education (ACPE) Psychotherapist, as determined by the ACPE. ACPE Psychotherapists are listed on the ACPE website at https://www.acpe.edu.*

_____ I have attached proof of membership as a fellow or diplomate member of the American Association of Pastoral Counselors (AAPC).

_____ I have attached proof of being an Association for Clinical Pastoral Education (ACPE) Psychotherapist.

Or

_____ I have attached proof that I meet the requirements to become a fellow or diplomate member of the AAPC. (Membership information for the AAPC can be obtained by writing to the AAPC at 9504-A Lee Highway, Fairfax, Virginia 22031 or by calling AAPC at (703)-385-6967)

Education: *has at least a master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline*

Date Graduated: ______________ Degree Earned: _____________________________
(mm/yyyy)

Name of University: ____

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Clinical Experience:

_____ Two hundred (200) hours of approved supervision in the practice of pastoral counseling, ordinarily to be completed in a 2-to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases;

AND

_____ 1,000 hours of clinical experience in the practice of pastoral counseling under approved supervision, involving at least 50 different cases;

OR

_____ 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3- year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of pastoral counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years;

AND

_____ 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in pastoral counseling under approved supervision, involving at least 20 cases.

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 / 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 ____

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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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