



TRICARE PROVIDER CERTIFICATION APPLICATION

CERTIFIED PHYSICIAN ASSISTANT (PA)

Per TRICARE requirements, TriWest Healthcare Alliance shall ensure all providers are TRICARE certified in accordance with 32 CFR 199.6 and TRICARE Policy Manual, Chapters 1 and 11.

Please submit the completed application package to provcerts@triwest.com.

Practitioner Information

*Required

First Name*:	MI:	Last Name*:	Suffix:
National Provider Identifier (NPI)*:	Sex*: M F	Date of Birth (MM/DD/YYYY)*:	SSN (XXX-XX-XXXX)*:
Phone Number (XXX-XXX-XXXX)*:	Email Address*:		

Are you employed by the U.S. government?*

Yes No

NOTE: Federal law (5 U.S.C. 5536) prohibits medical personnel, who are active duty service 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 medical provider, facility in which the care was rendered, or beneficiary/sponsor. 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.

Certification Information

To certify you as a **Certified Physician Assistant**, please provide the following information to confirm you meet TRICARE requirements. Failure to provide complete and accurate information will delay the certification process and may negatively impact claims processing.

1. Attach a copy of your state license and complete the following fields.

NOTE: If state licensure is available, it is required even if the state offers licensure on a voluntary basis.

State of Licensure*:	State License Number*:
License Effective Date (MM/DD/YYYY)*:	License Expiration Date (MM/DD/YYYY)*:

2. Complete the following fields for your Supervising Physician.

NOTE: Per TRICARE requirements, a PA may provide covered services under the general supervision of a physician. Physician supervision may be remote and does not require direct contact between the physician and PA at the time the care is rendered. The employing physician must be an authorized provider (for example, a physician under sanction by TRICARE also results in the PA being placed in unauthorized TRICARE provider status).

First Name*:	Last Name*:	National Provider Identifier (NPI)*:
State of Licensure*:	State License Number*:	
License Effective Date (MM/DD/YYYY)*:	License Expiration Date (MM/DD/YYYY)*:	



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3. Attach a copy of your national certification and complete the following fields.

Are you currently certified by the National Commission on Certification of Physician Assistants?*

Yes No

Certification Number*:	Certification Effective Date (MM/DD/YYYY)*:
Certification Expiration Date (MM/DD/YYYY)*:	

4. Complete the following fields regarding your education.

Have you successfully completed a PA program that was at least one academic year in length, consisted of supervised clinical practice, and at least four months of classroom instruction directed toward preparing students to deliver health care, and was accredited by the American Medical Association’s Committee on Allied Health Education and Accreditation?*

Yes No

Date Completed (MM/DD/YYYY)*:

Have you successfully completed a formal PA educational program that does not meet the requirements listed above and had been assisting primary care physicians for a minimum of 12 months during the 18-month period immediately preceding January 1, 1987?*

Yes No

Date Completed (MM/DD/YYYY)*:

Attestation

By signing below, I attest to meeting the above TRICARE requirements as well as confirm that the above information is accurate and complete to the best of my knowledge.

Signature*:	Date (MM/DD/YYYY)*:
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