TRICARE
CERTIFIED MARRIAGE AND FAMILY THERAPIST
PROVIDER APPLICATION

In addition to a completed application, TRICARE requires all Certified Marriage and Family Therapists to enter into the enclosed participation agreement. Also, copies of state licensure, proof of education and documentation of supervised clinical experience are required by TRICARE for certification.

Please submit the completed application package to:

Fax: 888-279-3540

OR

Mail to:
TRICARE North Region
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756

Note: Associate members or student members of the AAMFT are not eligible for consideration as authorized certified marriage and family therapists.

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TRICARE Non-Network Licensed Marriage and Family Therapist 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 or Mailing Address (If Different):

____

____

____

Telephone #: ___________________________

Fax #: _________________________________

Billing Telephone #: _____________________

Email: _________________________________

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

Group Practice Information

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 or Mailing Address (If Different):

____

____

____

Telephone #: ___________________________

Fax #: _________________________________

Billing Telephone #: _____________________

Email: _________________________________

** If you practice at multiple locations, please attach a list of additional office locations.

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To certify you as a **Certified Marriage and Family Therapist,** 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.

Home Address (Street Address): ______________________________
____

Emergency Telephone Number ________________________

Licensure: (please select your specialty)

☐ **Certified Marriage and Family Therapist:**
If licensure/certification as a marriage and family therapist 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: ______________

Please attach a copy of your license

In jurisdictions that **do not offer specific licensure or certification for marriage and family therapists, the provider must be certified or be eligible for full clinical membership in, the American Association for Marriage and Family Therapy (AAMFT), the national association that sets standards for the profession. If a provider is eligible for full clinical membership in the AAMFT but is not a member, he/she **must submit documentation** obtained from the AAMFT of such eligibility.*

☐ I have attached proof of membership as a full Clinical member of the American Association for Marriage and Family Therapy (AAMFT).

Or

☐ I have attached proof that I meet the requirements to become a full CLINICAL member of the AAMFT. (Membership information for the AAMFT can be obtained by calling the AAMFT at 703-838-9808)

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: ____

****TRICARE requires a copy of your transcript which includes the name and address of the educational institution.***

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Clinical Experience:

☐ Two hundred (200) hours of approved supervision in the practice of marriage and family, 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 marriage and family 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 marriage and family 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 marriage and family counseling under approved supervision, involving at least 20 cases.

Required Clinical Experience Details:

Dates of clinical experience: ________________ to ________________
mm/yyyy mm/yyyy

Supervisor Name: ____

Name of Institution: ____

Address of Institution: ____

____

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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TRICARE PARTICIPATION AGREEMENT FOR CERTIFIED MARRIAGE AND FAMILY THERAPISTS

____
Name of Certified marriage and family therapist

____
Office Address

____
Telephone

____
Tax ID Number

ARTICLE 1
RECITALS

1.1 Identification of Parties

This Participation Agreement is between the United States of America through the Department of Defense, Defense Health Agency (hereinafter DHA), a field activity of the Office of the Secretary of Defense, the administering activity for the Defense Health Agency (hereinafter DHA) and ____,
doing business as ____,
(hereinafter designated certified marriage and family therapist(s).

1.2 Authority for Certified marriage and family therapists as Authorized Providers

32 Code of Federal Regulations Part 199 provides for cost-sharing of services provided by certified marriage and family therapists under certain conditions.

1.3 Purpose of Participation Agreement

The purpose of this participation agreement is to:

(a) Establish the undersigned certified marriage and family therapist as an authorized provider of mental health services;

(b) Establish the terms and conditions that the undersigned certified marriage and family therapist must meet.

1.4 Billing Number

The certified marriage and family therapist's billing number for all mental health services rendered is the certified marriage and family therapist's social security number or employer's identification number (EIN). This billing number must be used until the provider is officially notified by DHA of a change. The certified marriage and family therapist's number is shown on the face sheet of this agreement. It is the only billing number that will be accepted by DHA claims processors after the effective date of this agreement for becoming an authorized certified marriage and family therapist.

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ARTICLE 2

PERFORMANCE PROVISIONS

2.1 General Agreement

The certified marriage and family therapists agrees to render medically necessary and appropriate covered mental health services within the scope of his practice and licensure to eligible beneficiaries as required by this participation agreement and the 32 CFR 199.6. The terms and conditions of 32 CFR 199.6 applicable to the participation or treatment of beneficiaries by the certified marriage therapists are incorporated herein by reference.

2.2 Licensure and Certification Requirements

The certified marriage and family therapist certifies and attaches hereto documentation that:

(a) He/she is now licensed or certified to practice as a marriage and family Therapists by the state in which practicing; or

(b) If practicing in a state which does not provide specific licensure or certification, the certified marriage and family therapist must be certified eligible for full clinical membership in the American Association for Marriage and Family Therapy; and

(c) He/she has a recognized graduate professional education with a minimum of an earned master's degree from an accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(d) He/she has the following experience:

(1) Either 200 hours of approved supervision in the practice of marriage and family 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

(2) 1000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases; or

(3) 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 marriage and family counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

(4) 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 marriage and family counseling under approved supervision, involving at least 20 cases.

2.3 The certified marriage and family therapist agrees that, having an exclusive election to participate as a certified marriage and family therapist, he or she will not be authorized in any other category of extra medical provider, either during or subsequent to the period this agreement is in effect.

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ARTICLE 3

PAYMENT PROVISIONS

3.1 Determined Allowable Charge

The determined allowable charge is the maximum amount that can be authorized for services rendered by an authorized individual professional provider of care. The determined allowable charge is determined following the provisions set forth in 32 CFR 199.14.

3.2 Determined Allowable Charge as Payment in Full.

The certified marriage and family therapist agrees to accept the determined allowable charge as payment in full for services rendered to beneficiaries, except applicable deductible and cost-shares.

3.3 Hold Harmless

The certified marriage and family therapist agrees to hold eligible beneficiaries harmless for non-covered care (i.e., certified marriage and family therapist may not bill a beneficiary for non-covered care and may not balance bill the beneficiary for amounts above the determined allowable charge).

ARTICLE 4

TERM, TERMINATION AND AMENDMENT

4.1 Term

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated by either party.

4.2 Termination of Agreement by DHA

The Executive Director, DHA, or designee, may terminate this agreement upon written notice, for cause, if the certified marriage and family therapist is found not to be in compliance with the provisions set forth in 32 CFR 199.6, or is determined to be subject to the administrative remedies involving fraud, abuse, or conflict of interest as set forth in 32 CFR 199.9. Such written notice of termination shall be an initial determination for purposes of the appeal procedures set forth in 32 CFR 199.10.

4.3 Termination of Agreement By the Certified marriage and family therapist

The certified marriage and family therapist may terminate this agreement by giving the Executive Director, DHA, or designee, written notice of such intent to terminate at least 60 days in advance of the effective date of termination. Effective the date of termination, the certified marriage and family therapist will no longer be recognized as an authorized provider, and reinstatement shall be disallowed for any other category of extramedical individual provider. Subsequent to termination, the certified marriage and family therapist may only be reinstated as an authorized extramedical provider by entering into a new participation agreement as certified marriage and family therapist.

4.4 Amendment by DHA

(a) The Executive Director, DHA or designee, may amend the terms of this participation agreement by giving 120 days notice in writing of the proposed amendment(s) except when necessary to amend this agreement from time to time to incorporate changes to the 32 CFR 199. When changes or modifications to this agreement result from changes to the 32 CFR 199 through rulemaking procedures, the Executive Director, DHA or designee, is not required to give 120 days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective.

(b) The certified marriage and family therapist, not wishing to accept the proposed amendment(s), including any amendment resulting from the changes to the 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the certified marriage and family therapist notice of intent to terminate its participation is not given at least 60

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days *prior* to the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into this agreement for services furnished by the certified marriage and family therapist between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 5

EFFECTIVE DATE

5.1 Date Signed

This participation agreement is effective on the date signed by the Executive Director, DHA, or designee.

DHA	Certified Marriage and Family Therapist
________________________________	________________________________
By: Signed Name	By: Signed Name
________________________________	________________________________
Title	Title
________________________________	________________________________
Print Name	Print Name
Executed on ________________, 20____	Date Signed: ______________________

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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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PGBA, LLC
TRICARE North EFT
PO Box 870154
Surfside Beach, SC 29587-9754
FAX 1-888-536-2324

Electronic Funds Transfer (EFT) Authorization Agreement

Please complete all fields on pages 1 and 2 of this form. Form Completion Guidelines and Terms and Conditions can be found on pages 2 and 3. Mail or fax the completed form along with required documentation to the address or fax number noted above. Please retain a copy of the completed EFT Authorization Agreement for your records.

Provider Information				
Provider Name:				
Provider Address:	Street:	City:	State:	Zip Code/Postal Code:

Provider Identifiers Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):	
National Provider Identifier (NPI) - *required when provider has been enumerated with an NPI:*	

☐	NOTE: Checking this box indicates payment for all locations of the above TIN to be transmitted to the Financial Institution Transit/Routing and Account number indicated on this EFT Authorization Agreement. Otherwise, if only specific locations are to be included, list them below. Attach additional sheets if necessary.

TRICARE Provider Number (with suffix):	National Provider Identifier (NPI):	Business Name and Address:

Provider Contact Information			
Provider Contact Name:		Telephone Number:	
Email Address:		Fax Number:	

Financial Institution Information			
Financial Institution Name:			
Financial Institution Routing Number:			
Type of Account at Financial Institution (check one):	Savings ☐	Checking ☐	
Provider's Account Number with Financial Institution:			
Account Number Linkage to provider Identifier (Must match ERA Preference) Check one:	Provider Tax Identification Number (TIN) ☐	National Provider Identification Number (NPI) ☐	

Note: If enrolled for 835 Electronic Remittance Advice (ERA), the provider must contact their financial institution to arrange for the delivery of the CORE-required minimum CCD+ data elements needed for association of the payment and the 835 ERA.

For assistance, contact our EDI Help Desk
1-877-334-2524 (1-877-EDI-CLAIM)
www.myTRICARE.com by PGBA

TRICARE North EFT
PO Box 870154
Surfside Beach, SC 29587-9754
FAX 1-888-536-2324

Submission Information							
Reason for Submission:	New Enrollment			Change Enrollment		Cancel Enrollment	
Include with Enrollment Submission:	Voided Check			Bank Letter			
Written Signature of Person Submitting Enrollment:							
Printed name of Person Submitting Enrollment:							
Printed Title of Person Submitting Enrollment:							
Submission Date:				Request EFT Start/Change/Cancel Date:			

Form Completion Guidelines

- Please type or print legibly using blue or black ink.
- To help expedite the process, you may enroll online at www.myTRICARE.com. In order to enroll online, you must have a myTRICARE Secure account. If you are not a registered myTRICARE Secure account holder, please go to www.myTRICARE.com to register.
- Please allow up to 4 weeks for the enrollment process which includes pre-note verification.
- Online instructions for checking the status of EFT payments can be found at www.myTRICARE.com.
- Once enrolled, EFT payments that have not been received after 4 business days of receipt of the corresponding ERA, online, or paper remittance can be researched by calling TRICARE North Region Customer Service at 1-877-874-2273.
- If you have any questions regarding the information contained in the EFT Authorization Agreement, please contact the TRICARE North EDI Help Desk at 1-877-334-2524.
- Mail or fax the completed form along with required documentation to:

PGBA, LLC
TRICARE North EFT
PO Box 870154
Surfside Beach, SC 29587-9751

Fax: 1-888-536-2324

Provider Information	
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider.
Provider Address	Street - The number and street name where a person or organization can be found.
	City - City associated with provider address field.
	State/Province - ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country
	Zip Code/Postal Code - System of postal zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities
Provider Identifiers	
Provider Federal Tax Identification Number (TIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions

For assistance, contact our EDI Help Desk
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Provider Contact Information	
Provider Contact Name	Name of a contact in provider office for handling EFT issues.
Telephone Number	Associated with contact person.
Email Address	An electronic mail address at which the health plan might contact the provider.
Fax Number	A number at which the provider can be sent facsimiles.
Financial Institution Information	
Financial Institution Name	Official name of the provider's financial institution.
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are deposited.
Type of Account at Financial Institution	The type of account the provider will used to receive EFT payments (e.g., Checking, Savings).
Provider Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited.
Account Number Linkage to Provider Identifier	Provider preference for grouping (bulking) claim payments - must match preference for V5010 X12 835 remittance advice. Must select one of the following: Provider's Tax Identification Number (TIN) or National Provider Identifier (NPI).
Submission Information	
Reason for Submission	New Enrollment, Change Enrollment, Cancel Enrollment
Include with Submission	Voided Check - A voided check is attached to provide confirmation of Identification/Account Numbers.
	Bank Letter - A letter on bank letterhead that formally certifies the account owners routing and account numbers.
Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.
Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrolment.
Submission Date	The date on which the enrollment is submitted.
Requested EFT Start/Change/Cancel Date	The date on which the requested action is to begin.

TERMS AND CONDITIONS FOR ELECTRONIC FUNDS TRANSFER

By completing and submitting this form, your company agrees to accept payment by PGBA, LLC (PGBA) through electronic funds transfer (EFT). Additionally, you acknowledge and agree that all payments shall be made in accordance with the information that you supply on the Electronic Funds Transfer Authorization Agreement and that PGBA shall be entitled to rely exclusively upon such information. This agreement applies to and amends all existing agreements with PGBA by incorporating the following terms and conditions for electronic payment.

PGBA will initiate payment to you based on the following:

1. PBGA will transfer funds electronically to the financial institution and account number you register on this EFT Authorization Agreement.
2. PGBA will make payments in accordance with and be governed by the National Automated Clearinghouse Association's Corporation Trade Payment Rules. Our process is governed by and in accordance with the laws, other than choice of law provision of any particular contract, of South Carolina, including Article 4A of the Uniform Commercial Code as enacted by South Carolina and amended from time to time.
3. The information you provide on the EFT Authorization Agreement is very important. PGBA shall not be liable for any loss which may arise solely by reason of error, mistake, or fraud regarding this information. You understand that you must communicate any change in this information to PGBA. This communication must be in the form of a new EFT Authorization agreement faxed to this number: **1-888-536-2324**
4. Payment is initiated within the normal terms of our agreement with you and/or applicable TRICARE procedures. Our EFT terms and conditions neither enlarge nor diminish the parties' respective rights and obligations within any applicable agreement. The payment due date is not affected. We will consider payment made when your financial institution has received or has control of the payment transaction. This will generally occur within three (3) calendar days following initiation by PGBA. If payment is initiated on a nonbanking day at PGBA's originating bank, the funds transfer will occur the following banking day. In all cases, "Banking Day" is defined as the day on which both trading partners' banks are available to transmit and receive these fund transfers.
5. With respect to the EFT reimbursement process, PGBA is responsible up to the point where your financial institution receives or has control of the transaction. Any loss of data at that point will be borne by you unless the loss is due solely to the negligence of PGBA or its originating bank.

You hereby represent that you are authorized to enter into this agreement, disburse funds, sign checks and modify account information for the provider locations listed in this EFT Authorization Agreement.

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