TRICARE
GROUP MENTAL HEALTH COUNSELOR
PROVIDER APPLICATION

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

PGBA, LLC
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756
1-877-TRICARE (1-877-874-2273)
Fax 1-888-279-3540
www.myTRICARE.com by PGBA

Revised: 1/20/2015

NON-NETWORK TRICARE PROVIDER FILE APPLICATION
CLINIC OR GROUP PRACTICE
PROFESSIONAL ASSOCIATION, CORPORATION, PARTNERSHIP, CLINIC, ETC

Group Name: _____

Tax ID Number: _____

Group NPI Number: _____

Office Location (Street Address):

_____

_____

_____

Billing Address (If different):

_____

_____

_____

Office Phone No: _____

Billing Phone No: _____

Fax Number: _____

E-mail Address: _____

Date legal entity established _____

PLEASE complete one application for EACH location.

Will each Physician sign their own claim form ☐ YES ☐ NO
If No, Signature Authorization forms are attached. Please complete these forms and have them notarized.

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GROUP MEMBER LISTING

Please list all of the Providers affiliated with your group.

PLEASE COMPLETE ALL REQUIRED INFORMATION AND RETURN WITH COPY OF PROFESSIONAL LICENSES, COVER LETTER AND APPLICATION.

PHYSICIAN NAME (LAST, FIRST, MID)	SSN NUMBER	NPI NUMBER	PRIMARY SPECIALTY	DATE JOINED GRP
1. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: _____ EXPIRATION DATE: _____				
2. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: _____ EXPIRATION DATE: _____				
3. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: _____ EXPIRATION DATE: _____				
4. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: _____ EXPIRATION DATE: _____				
5. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: _____ EXPIRATION DATE: _____				
6. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: _____ EXPIRATION DATE: _____				
7. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: _____ EXPIRATION DATE: _____				
8. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: _____ EXPIRATION DATE: _____				

PLEASE PHOTOCOPY THIS FORM IF YOU HAVE MORE THAN EIGHT PHYSICIANS IN YOUR GROUP.

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TRICARE CERTIFIED MENTAL HEALTH COUNSELOR (TCMHC)
SECTION D

TRICARE Certified Mental Health Counselor (TCMHC) must meet the following requirements:

Provider Name: _____

1. Has passed the National Clinical Mental Health Counselor Examination (NCMHCE) or an examination determined by the Director, Defense Health Agency (DHA) as equal in scope, intent, and content to the NCMHCE.

Specify which Examination: _____

Date passed: _____
(PROOF OF PASSED EXAMINATION MUST BE ATTACHED)

AND

2. Possesses 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 Counseling by the Council for Accreditation of Counseling and Related Educational Programs (CACREP).

Date Graduated: _____ Degree Type: _____

Name of University: _____
(ATTACH COPY OF DEGREE)

AND

3. 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, TCMHCs, or certified psychiatric nurse specialists 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

4. Licensed for independent practice in the state where services are rendered.

License Number: _____

Original License Date: _____ Expiration Date: _____
(ATTACH COPY OF LICENSE)

OR

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TRICARE CERTIFIED MENTAL HEALTH COUNSELOR (TCMHC)
SECTION D

During the transition period lasting until January 1, 2017, TRICARE Certified Mental Health Counselor (TCMHC) may meet the following requirements:

Provider Name: _____

1. Possesses 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 Counseling by CACREP and has passed the National Counselor Examination (NCE).

OR

2. Possesses 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 Counseling by CACREP or from an educational institution accredited by a Regional Accrediting Organization recognized by the Council for Higher Education Accreditation and has passed the NCMHCE.

Date Graduated: _____ Degree Type: _____

Name of University: _____
(ATTACH COPY OF DEGREE)

NCMHCE Date passed: _____ NCE Date passed: _____
(PROOF OF PASSED EXAMINATION MUST BE ATTACHED)

AND

3. 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, TCMHCs, or certified psychiatric nurse specialists 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

4. Licensed for independent practice in the state where services are rendered.

License Number: _____

Original License Date: _____ Expiration Date: _____
(ATTACH COPY OF LICENSE)

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SUPERVISED MENTAL HEALTH COUNSELOR (SMHC)
SECTION D

Supervised Mental Health Counselor (SMHC)

For purposes of TRICARE, an SMHC is an individual who does not meet the requirements of a certified mental health counselor but meets the following requirements and abides by the conditions of reimbursement:

Provider Name: _____

1. Possesses a minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited educational institution.

Date Graduated: _____ Degree Type: _____

Name of University: _____
(ATTACH COPY OF DEGREE)

2. Has had 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

3. Licensed in the state in which practicing,

License Number: _____

Original License Date: _____ Expiration Date: _____
(ATTACH COPY OF LICENSE)

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Revised: 1/20/2015

PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

STATE OF _____

COUNTY OF _____

_____ being first duly sworn, deposes and says: I hereby authorize the Fiscal Intermediary for the Defense Health Agency Office, (TRICARE) in the State of South Carolina to accept my facsimile or stamp signature shown below 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 full-payment concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE/VA claim forms.

_____ FACSIMILE OR STAMP SIGNATURE
SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____DAY OF _____20___

_____
NOTARY PUBLIC IN AND FOR

COUNTY OF _____ STATE OF _____

(SEAL) MY COMMISSION EXPIRES _____

Per DHA guidelines, we may accept, in lieu of a provider's actual signature on a TRICARE claim form, a facsimile signature or a signature of a representative if the FI has on file a notarized authorization from the provider for use of a facsimile signature or a notarized authorization of Power of Attorney for another person to sign on his or her behalf.

The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim form is computer-generated.

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PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

STATE OF _____ COUNTY OF _____

Know all person by these presents:

That I, _____ have made, constituted and appointed and by these presents do make constitute and appoint _____ (Please attach a list of any other authorized representatives) 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 the Defense Health Agency (DHA). My signature by my said Attorney-In-Fact includes my agreement to abide by the full payment concept and remainder of the certification appearing on all TRICARE/VA 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 OF _____ STATE OF _____

(SEAL) MY COMMISSION EXPIRES _____

Per DHA guidelines, we may accept, in lieu of a provider's actual signature on a TRICARE claim form, a facsimile signature or a signature of a representative if the FI has on file a notarized authorization from the provider for use of a facsimile signature or a notarized authorization of Power of Attorney for another person to sign on his or her behalf.

The authorized representative may sign using the provider's name followed by the representative's initials or using the representative's own signature followed by "POA" (Power of Attorney), or similar indication of the type of authorization granted by the provider.

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Revised: 1/20/2015

PGBA
A CELERIAN GROUP COMPANY

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

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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

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FAX 1-888-536-2324

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.

Revised: 4/22/2015