



Autism Services Demonstration Certification

Dear Provider,

Date of Application ____ / ____ / ____

To become an authorized TRICARE provider or update your certification, please complete and return all applicable forms within thirty (30) days. Services should not be provided to TRICARE beneficiaries until you have received notification from TriWest that you meet the Demonstration Project criteria. Any services provided to TRICARE beneficiaries prior to your approval will result in denial of your claims.

Complete the enclosed forms (if applicable)

1. Clinic or Group Application.
2. Individual Application Forms that apply.
3. Attach copies of applicable documentation:
 - Copy of current unexpired state license, if applicable
 - Copy of Behavior Analyst Certification Board certificate (if board certified)
 - Copy of current unexpired malpractice declaration sheet, minimum of \$1 million per claim/\$3 million in aggregate required, unless there are different state requirements (evidence of professional liability insurance which indicates coverage limits and expiration dates)
 - Current resume / Curriculum Vitae (use month and year to indicate time for education, training and work history)
4. Signatures: (check one of the following options)
 - Your staff may sign TRICARE claim forms on your behalf when the necessary Authorized Signer form has been completed.
 - Computer Generated Facsimile or Rubber Stamp Authorization may also be used when the necessary agreement is on file. Computer generated "Signature on file" is not acceptable.
 - An original signature by the individual provider.
5. Complete W-9.

Please type or print legibly, ensure that the attestation and release forms are signed and dated by the practitioner. Please do not use whiteout. If the application is not complete, signed and dated or if whiteout is used, it will not be processed. Please use additional sheets if you need to provide additional information.

Thank you for your cooperation and prompt response.

Sincerely,

TriWest Credentialing Department

Please return to: TriWest Healthcare Alliance
Attn: Provider Services
P.O. Box 42049
Phoenix, AZ 85080

TO BE USED FOR THE AUTISM SERVICES DEMONSTRATION ONLY

PERSONAL INFORMATION				
PROVIDER'S NAME (Last Name, First Name, MI, Degree)			MAIDEN NAME (If Applicable)	SOCIAL SECURITY NUMBER
DATE OF BIRTH MM DD YY	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	PLACE OF BIRTH (City, State, Country)		FOREIGN LANGUAGES: <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write
MEDICARE #: UPIN #:	Individual NPI #: Group NPI #:	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you are not a U.S. Citizen, are you lawfully authorized to work in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PRACTICE/OFFICE INFORMATION			
Practice/Group Name:			Federal Tax ID#
Office Location (Street Address):		Billing Address (if different):	
Office Phone () () ()	Office Fax: () () ()	Billing Phone: () () ()	Billing Fax: () () ()
Additional Practice Location (use a separate sheet to submit additional practice locations)			
Office Location (Street Address):		Billing Address (if different):	
Office Phone () () ()	Office Fax: () () ()	Billing Phone: () () ()	Billing Fax: () () ()
Provides remote supervision <input type="checkbox"/> Yes <input type="checkbox"/> No			

EDUCATION AND TRAINING			
Have you earned a degree from an accredited education institution? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please complete this section.			
Name of School/Institution:	Address, City, State, Zip:	Year Earned:	Degree Earned:

SPECIALTY
LIST ALL SPECIALTIES PRACTICED, BEGIN WITH PRIMARY SPECIALTY
Primary:
Secondary:

STATE LICENSE/CERTIFICATION INFORMATION					
Please list all Current and Previous Licenses or State Certifications in all jurisdictions. (Attach a copy of all licenses/certificates)					
State of Issue	Number	Current	Original Issue Date	Current Issue Date	Expiration Date
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			

Educational Interventions for Autism (EIA) Supervisor Certification Requirements

Please attest to one of the requirements listed below and provide any requested documentation.

- Evidence of Professional Liability Insurance in the amounts of \$1 million per claim and \$3 million in aggregate; **please attach a copy of your malpractice certificate.**
 - I verify that I have a current, unrestricted State-issued license to provide ABA services (submit copy); **OR**
 - I verify that I have a current, unrestricted State-issued certificate as a provider of ABA services (submit copy); **OR**
 - I verify am certified by the BACB (<http://www.bacb.com>) as either a BCBA or a BCABA where such state-issued license or certification is not available;
- AND**
- I verify that I employ directly or contract with EIA Tutors.
- AND**
- I verify that all applicable business licenses and employment or contractual documentation are maintained in accordance with Federal, State, and local requirements.

Signature

Date

Educational Interventions for Autism (EIA) Tutors Certification Requirements

Please include detailed information for any Tutors in which you supervise.

The qualifications for EIA Tutors are outlined below. Use this information as a guideline and verify that each tutor in which you supervise meets these qualifications:

- Completed 40 hours of classroom training in ABA techniques in accordance with the BACB Guidelines for Responsible Conduct for Behavior Analysts (<http://www.bacb.com>),

AND

- Undergone a criminal background check;

AND

- Complete a minimum of 12 semester hours of college coursework in psychology, education, social work, behavioral sciences, human development or related fields and be currently enrolled in a course of study leading to an associate's or bachelor's degree by an accredited college or university; **OR**
- Completed a minimum of 48 semester hours of college courses in an accredited college or university; **OR**
- A High School diploma or GED equivalent and have completed 500 hours of employment providing ABA services as verified by the ACSP;

AND

- Receives no less than two hours supervision per month from the EIA Supervisor, in accordance with the BACB Guidelines for Responsible Conduct for Behavior Analysts.

CONFLICT OF INTEREST STATEMENT

For TRICARE providers:

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

I, _____ hereby certify and attest to the fact that all the information submitted by me in this application is true and accurate to the best of my knowledge and belief.

Signature

Date

**CONSENT TO THE INSPECTION OF RECORDS AND DOCUMENTS
RELEASE OF INFORMATION AND LIABILITY**

I, _____ hereby authorize TRIWEST HEALTHCARE ALLIANCE – its professional staff and legal representatives for the purpose of evaluating my professional competence, character, criminal history and ethical conduct, to contact and consult with administrators and members of the professional staff of any treatment facility, institution, professional society, school, employer, law enforcement agency, or practice with which I have been associated. In addition, I consent to the inspection by TRIWEST HEALTHCARE ALLIANCE – its professional staff and legal representatives of all records and documents, including health records at other treatment facilities that may be material for evaluation of my professional qualifications. I also release from liability all individuals or organizations for their acts performed in good faith and without malice who honestly initiate and respond to the inquiries authorized for use by TRIWEST HEALTHCARE ALLIANCE. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Signature

Date

INSERT DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE
FORM W-9