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16010 North 28th Avenue  
Phoenix, Arizona 85053  
Main: 1-888-TRIWEST (874-9378)  
[www.triwest.com](http://www.triwest.com)

TriWest Healthcare Alliance Corp. would like to take this opportunity to thank you for your desire to care for TRICARE beneficiaries. Providing quality health care helps ensure that active duty service members, military retirees and their family members are well served. Deployed service members especially take great comfort knowing their family members' health care is secure.

TriWest has made accessing information about the TRICARE program on [www.triwest.com/provider](http://www.triwest.com/provider) easy and convenient for you and your business office staff. Once registration is authenticated, you have direct access to the secure provider portal, allowing you to:

- Verify patient eligibility
- Submit referrals/authorizations online
- Determine status of referrals/authorizations
- Submit claims online
- View claims and check claim status
- Download Explanations of Benefits

In addition, [www.triwest.com/provider](http://www.triwest.com/provider) has several resources located to help you find information regarding TRICARE reimbursement rates, referrals and authorizations, claims and reimbursement, TRICARE programs and benefits, Electronic Data Interchange (EDI), the Resource Library, and more!

Here are some other sources that are designed to assist you in providing care to beneficiaries:

- The **Interactive Voice Response (IVR) system** is available 24-7 by calling 1-888-TRIWEST (874-9378). An IVR Tips Guide is available in the Resource Library at [www.triwest.com/provider](http://www.triwest.com/provider) to guide you through the process.
- **TRICARE Field Representative (TFR)** You may call 1-888-TRIWEST (874-9378) to request the assistance of your local TFR if you need assistance with the TRICARE certification process or if you require education regarding TRICARE.
- **TriWest's eSeminars** offer the convenience of learning about TRICARE programs in the comfort of your office, home or any location with Internet access at a time most convenient to you. Go to [www.triwest.com/provider](http://www.triwest.com/provider) to take an eSeminar.
- **Filing Claims: Electronic Data Interchange (EDI)** Wisconsin Physicians Service (WPS) staff is skilled in implementing EDI strategies with a variety of provider specialties, billing services, and software vendors. Choosing one of their electronic data interchange (EDI) options assures you ample assistance throughout the claims filing process. The EDI edit systems are designed to minimize data entry errors before claims are passed to the WPS processing system. EDI claims are generally processed and paid very quickly.

Thank you again for your interest in providing care to TRICARE beneficiaries in the West Region. For additional information on registering for the secure provider portal, submitting your claims online and signing up to receive ERA, refer to [www.triwest.com/provider](http://www.triwest.com/provider), or call 1-800-782-2680 (EDI Help Desk).

A handwritten signature in black ink that reads "Lisa Stevens".

Vice President, Provider Services  
TriWest Healthcare Alliance

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**TRICARE West Region**  
"Whatever It Takes"

# MARRIAGE AND FAMILY THERAPISTS PROVIDER FILE APPLICATION

**FAILURE TO COMPLETE AND SIGN THIS CERTIFICATION  
WILL RESULT IN DENIAL OF FUTURE CLAIM PAYMENT**

Date of Request \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_

Federal Tax ID \_\_\_\_\_ National Provider Identifier (NPI) # \_\_\_\_\_

Medicare # \_\_\_\_\_

**Office location** (Street address):

**Billing address** (if different):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you joining an established group practice?  Yes  No

If Yes:

Group name \_\_\_\_\_

You must complete the Special Authorization form if the group will bill on your behalf.

Date you began filing with the group provider # \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Do you maintain a solo practice?  Yes  No

**Are you:**

Hospital employed or contracted?

Yes  No \_\_\_\_\_

Teaching setting?

Yes  No \_\_\_\_\_

Employed by the U.S. Government?

Yes  No \_\_\_\_\_

LICENSE # \_\_\_\_\_

Temporary

**Enclose copy of licensure/certification.**

Permanent Issuing State \_\_\_\_\_

Date license was first issued \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Expiration Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Dates are mandatory for claim payment and must be updated when renewed.

**Participation agreements must be completed and signed to be eligible for TRICARE benefits.**

The provider must possess a valid state license or certificate as a marriage and family counselor, or hold a license or certificate that allows the individual to provide marriage and family counseling in states which offer such licensing or certification.

In those states which do not provide for licensure, the marriage and family counselor must, in addition to meeting the other requirements listed in this section, be (or be eligible to become) a clinical member of the American Association of Marriage and Family Therapists. A copy of its annual register may be obtained by writing to:

American Association for Marriage and Family Therapy  
1100 Seventeenth St., NW, The Tenth Floor  
Washington, D.C. 20036-4601  
(202) 452-0109

I certify that I am currently a member or a fellow of the American Association of Marriage and Family Therapists.

Yes  No  Eligible (If eligible is checked, please provide letter of acceptance from AAMFT.)

**In addition**, marriage and family therapists must have a recognized graduate professional education with the minimum of an earned master's degree from an accredited educational institution in an appropriate behavioral science field or mental health discipline.

Name and location of school: \_\_\_\_\_

Degree earned: \_\_\_\_\_ Year earned: \_\_\_\_\_

Field of study: \_\_\_\_\_

One of the following experience requirements must also be met:

- A. 200 hours of approved supervision of 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. The supervision will occur preferably with more than one supervisor 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.
  
- B. 150 hours of approved supervision of 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 and 50 hours of approved individual supervision of the practice of marriage and family counseling, ordinarily to be completed within a period of not less than 1 or more than 2 years, and at least 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases, and 250 hours of clinical practice of marriage and family counseling under supervision, involving at least 20 cases.

I certify that I have completed at least the number of hours of practice required in:  A  B

Signature \_\_\_\_\_

### 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.

Please return to: WPS TRICARE Provider Certification  
P.O. Box 8730  
Madison, WI 53708-8730

Please notify us of any changes related to your provider file information (name, address, specialty, tax number, group affiliations, etc.).

# TRICARE PARTICIPATION AGREEMENT FOR CERTIFIED MARRIAGE AND FAMILY THERAPISTS

\_\_\_\_\_  
Name of certified marriage and family therapist

\_\_\_\_\_  
Office Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Tricare provider billing number

## ARTICLE 1

### RECITALS

#### 1.1 Identification of Parties.

This Participation Agreement is between the United States of America through the Department of Defense, TRICARE, a field activity of the Secretary of Defense, the administering activity for TRICARE and

\_\_\_\_\_ doing business as \_\_\_\_\_ (hereinafter designated certified marriage and family therapist).

#### 1.2 Authority for Certified Marriage and Family Therapists as Authorized Providers under TRICARE.

The TRICARE Department of Defense Regulation (DoD) 6010.8-R, (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 a TRICARE 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 TRICARE 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 TRICARE claims processors after the effective date of this agreement for becoming an authorized certified marriage and family therapist under TRICARE.

## ARTICLE 2

### PERFORMANCE PROVISIONS

#### 2.1 General Agreement.

The certified marriage and family therapist agrees to render medically necessary and appropriate covered mental health services within the scope of his practice and licensure to eligible TRICARE beneficiaries as required by this participation agreement and DOD 60101.8-R. The terms and conditions of DoD 6010.8-R are applicable to the participation or treatment of TRICARE beneficiaries by the certified marriage and family therapist 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 therapist 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 by or be 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 experiences;
  - (1) Either 200 hours of approved supervision in the practice of marriage and family counseling, ordinarily to be completed in a two-to-three 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) 1,000 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 two-to-three 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 two 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 in TRICARE as certified marriage and family therapist, he or she will not be authorized in any category of extramedical provider, either during or subsequent to the period this agreement is in effect.

## ARTICLE 3

## **PAYMENT PROVISIONS**

### **3.1 TRICARE Determined Allowable Charge.**

The TRICARE determined allowable charge is the maximum amount that TRICARE will authorize for services rendered by a TRICARE authorized individual professional provider of care. The TRICARE determined allowable charge is determined following the provisions set forth in DoD 6010.8-R, Chapter 14.

### **3.2 TRICARE determined Allowable Charge as Payment in Full.**

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

### **3.3 Hold Harmless**

The certified marriage and family therapist agrees to hold eligible TRICARE 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 any amount above the TRICARE determined allowable charge).

<b>ARTICLE 4</b>
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## **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 the Office of TRICARE.**

The Director, TRICARE 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 DoD 6010.8-R, Chapter 6, or is determined to be subject to the administrative remedies involving fraud, abuse, or conflict of interest as set forth in DoD 6010.8-R, Chapter 9. Such written notice of termination shall be an initial determination of purposes of the appeal procedures set forth in DoD 6010.8-R, Chapter 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 Director, TRICARE, 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 under TRICARE, and reinstatement shall be disallowed for any other category of extramedical individual provider under TRICARE. Subsequent to termination the certified marriage and family therapist may only be reinstated as an authorized TRICARE extramedical provider by entering into a new participation agreement as a certified marriage and family therapist.

### **4.4 Amendment by the Office of TRICARE.**

- (a) The Director, TRICARE, 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 TRICARE regulations. When changes or modifications to this agreement result from changes to TRICARE regulations through rulemaking procedures, the Director, TRICARE, or designee, is not required to give 120 days written notice.

Any such changes to DoD 6010.8-R 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 changes to the TRICARE regulations accomplished through rulemaking procedures, may terminate participation as provided for in this article. However, if the certified marriage and family therapist notice of intent to terminate participation is not given at least 60 days prior to the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into the 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.

<b>ARTICLE 5</b>
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**EFFECTIVE DATE**

**5.1 Date Signed.**

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

TRICARE

Certified Marriage and Family Therapist

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
By: Typed Name and Title

\_\_\_\_\_  
By: Typed Name and Title

Executed on \_\_\_\_\_, 20\_\_\_\_\_.

18656-097-0906



**AUTHORIZED SIGNER**

If a provider elects to use a facsimile signature (rubber stamp) or allow a representative to sign his/her name for certification of the services rendered, it is a TRICARE requirement that we have an authorization from the provider.

Hospital/Clinic Name: \_\_\_\_\_ Hospital/Clinic IRS Tax Number: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Each of the below named representatives of this organization are hereby authorized to complete and sign all claim forms required by TRICARE and any related documentation that might be required by fiscal administrators of TRICARE on behalf of all physicians, dentists and other allied science professional staff members for authorized services, care and treatment rendered in the hospital or clinic to TRICARE patients.

The undersigned understands that this is continuing authorization and that the data on such claim forms is entered with the same authority, accuracy and effect as though executed by a member of the professional staff on whose behalf the form is completed. We understand that this authorization shall remain in effect until cancelled or modified in writing by the undersigned or our successors in office.

The agents' signatures and typed names and official titles with the organization as authorized above are as follows:

\_\_\_\_\_  
Signature Printed Name Official Title

\_\_\_\_\_  
Signature Printed Name Official Title

\_\_\_\_\_  
Signature of President (or other authorized officer of the governing body of the hospital, clinic or association) Date

**COMPUTER GENERATED FACSIMILE OR RUBBER STAMP AUTHORIZATION**

Name: \_\_\_\_\_ NPI #: \_\_\_\_\_ IRS Tax#: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

\_\_\_\_\_ being first duly sworn, deposes and says: I hereby authorize Wisconsin Physicians Service Insurance Corporation to accept my facsimile or stamp signature, shown below, as my true signature for all purposes under the TRICARE program in the same manner as if it were my actual signature.

\_\_\_\_\_  
Actual Signature (Facsimile or Stamp Signature)

Subscribed and sworn to before me this \_\_\_\_\_ (date) day of \_\_\_\_\_ (month), 20\_\_\_\_\_.

NOTARY PUBLIC IN AND FOR \_\_\_\_\_

county, state of \_\_\_\_\_, my commission expires \_\_\_\_\_ (SEAL)