

Application Form For Corporate Services Providers

(TRICARE
Contractor's
Letterhead)

APPLICATION FOR TRICARE-PROVIDER STATUS

OMB No. 0720-XXXX
Expires XXX XX, XXXX

CORPORATE SERVICES PROVIDER

The public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-XXXX), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR APPLICATION TO THE ABOVE ADDRESS.

DIRECTIONS

- To apply for certification as a TRICARE-authorized provider, read and complete all sections of this application and return it with all attachments to the following address:

(Contractor's Name
Contractor's Provider Certification Unit
Address)

- *For inquiries, please call (Contractor's provider-inquiry telephone number).*

Provider name:

NOTE: All Applications must be signed by the chief executive officer and dated.

The above-named provider has applied to become a TRICARE-authorized provider. The signee certifies that the information in this application and attachments is true and accurately represents and depicts the above-named provider.

Chief Executive Officer

Date

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 11, Addendum D

Application Form For Corporate Services Providers

Application for TRICARE-Provider Status:

INSTITUTION/CORPORATE SERVICES PROVIDER

Identification Information:

Name: _____

Corporate/foundation name if different: _____

ADDRESS:

Physical location (street, city, state, ZIP):

Mailing address (if different):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Area code and TELEPHONE NUMBER:

Area code and FACSIMILE NUMBER:

TAX ID NUMBER:

Are you a MEDICARE provider? Yes _____ No _____

If yes: Medicare certification number:

Medicare Category:

Medicare acceptance date:

Are you a JCAHO accredited? Yes _____ No _____

If yes: JCAHO classification:

Original JCAHO classification date:

Current JCAHO classification dates FROM:

TO:

STATE license classification: _____

Dates of state licensure FROM: _____ TO: _____

Are you certified by a national board? Yes _____ No _____

If yes: Name of board:

Effective date of certification:

IMPORTANT: Please attach copies of applicable Medicare, JCAHO, state, and national board certificates/licenses.

- END -