

CHAPTER 11  
ADDENDUM E

APPLICATION FORM FOR CORPORATE SERVICES PROVIDERS

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(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 inquires, 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 6010.54-M, AUGUST 1, 2002**  
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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 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.***