Chapter 11 Addendum C

Application Form For Corporate Services Providers

Revision: C-13, November 15, 2017

(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: _____

FIGURE 11.C-1 TRICARE CORPORATE SERVICES APPLICATION

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:

_____

National Provider Identifier (NPI) #

_____

Are you a MEDICARE provider: ( ) Yes ( ) No

If yes: Medicare certification number: _____

Medicare Category: _____

Medicare acceptance date: _____

Are you JC accredited? ( ) Yes ( ) No

If yes: JC classification: _____

JC classification dates: FROM: _____ TO: _____

State License classification: _____

State License dates: FROM: _____ TO: _____

Are you certified by a national board? ( ) Yes ( ) No

If yes: Name of National board: _____

Effective date of certification: _____

- END -