

## 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 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 6010.60-M, April 1, 2015**

Chapter 11, Addendum C

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**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 -