

TRICARE South Region Application

PLEASE READ

Provider Eligibility for the TRICARE South Region Network

This application is to be used only for consideration in the ValueOptions/TRICARE South Region network, and cannot be used when requesting participation in the ValueOptions Commercial, EAP, or Public Sector networks.

Before completing the TRICARE South Region Provider Application for network eligibility, please review the following summary of minimum criteria for consideration. Providers are required to be credentialed through the ValueOptions process. An executed Provider Agreement will be sent to you prior to your receiving TRICARE referrals.

The ValueOptions TRICARE South Region provider network criteria are as follows:

Psychiatrists/Addictionologists

- ◆ Must have an unrestricted license as an MD or DO in the state where services are provided; or have received special State licensure if employed by a college or university.
- ◆ Must have one of the following: Board Certification in psychiatry; evidence of having completed a residency program in psychiatry; or American Society of Addiction Medicine (ASAM) certification.
- ◆ Have a current Drug Enforcement Administration (DEA) Certificate.
- ◆ Submit an Education Council for Foreign Medical Graduates (ECFMG) Certificate, if a graduate of a foreign medical school.
- ◆ Are participating Medicare providers.

Family Practice / Pediatric MD/DO – Behavioral Health Criteria

- ◆ Must meet the licensure, DEA and ECFMG criteria for Psychiatrists/Addictionologists (above).
- ◆ Board Certification in Family Practice or Pediatrics, with sub-certification in Developmental Behavioral Pediatrics or Neurodevelopmental Disabilities, OR evidence of having completed a residency program in Family Practice or Pediatrics and a fellowship in Developmental Behavioral Pediatrics or Neurodevelopmental Pediatrics or Behavioral Medicine.

Psychologists

- ◆ Have an unrestricted license to practice as a **clinical** psychologist in the state where services are provided.
- ◆ Have a doctoral degree in psychology (PhD, EdD, PsyD) from an accredited college or university.
- ◆ Are participating Medicare providers.

Nurse Practitioners

- ◆ Must have unrestricted licenses to practice as a Nurse Practitioner with Psychiatric Nursing as the specialty in the state where services are provided.
- ◆ Must have a Master's degree from an accredited college or university in a program recognized by the American Nursing Association (ANA).
- ◆ Are participating Medicare providers.

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Psychiatric Nurses

- ◆ Have an unrestricted licensed to practice at the highest level of independent practice in the state where services are provided.
- ◆ Must have a Master's degree in psychiatric nursing from an accredited college or university in a program recognized by the American Nursing Association (ANA).
- ◆ Must be certified by the American Nurses Credentialing Center (ANCC).

Social Workers

- ◆ Have an unrestricted licensed to practice at the highest level of independent practice in the state where services are provided.
- ◆ Have a Master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education.
- ◆ Are participating Medicare providers.

Marriage and Family Therapists

- ◆ Have unrestricted licenses to practice at the highest level of independent practice in the state where services are provided.
- ◆ Have a Master's degree from an accredited educational institution in an appropriate behavioral science field or mental health discipline.

Mental Health Counselors/Other Clinicians

- ◆ Have an unrestricted license to practice at the highest level of independent practice in the state where services are provided.
- ◆ Have a Master's degree in mental health counseling or allied mental health field from a regionally accredited institution.

Pastoral Counselors

- ◆ Have an unrestricted license to practice as a Pastoral Counselor in the state where services are provided. In states that do not offer licensure, a Pastoral Counselor must be (or must meet all the requirements to become) a fellow or diplomate member in the American Association of Pastoral Counselors (AAPC) as determined by the AAPC.
- ◆ Have a Master's degree in mental health counseling or allied mental health field from a regionally accredited institution.

Mental Health Counselors/Other Clinicians and Pastoral Counselors are required to have physician referral prior to the initial patient evaluation, and physician oversight must continue throughout the course of therapy in order to be reimbursed by TRICARE. This is a regulatory TRICARE requirement that cannot be altered or waived.

Professional Liability Coverage (Applicant's name must be included on the policy face sheet):

Physicians and Nurse Practitioners: \$1,000,000.00 per individual episode; \$3,000,000.00 aggregate.

All other clinicians: \$1,000,000.00 per individual episode; \$1,000,000.00 aggregate.

TRICARE South Region Application CHECK OFF SHEET

To ensure timely processing, please attach copies of the required documents listed below, in addition to your completed and signed TRICARE South Region Provider Application. All documents must be current. Incomplete applications will be returned.

Please mark those items attached:

- Signed copy of the TRICARE Provider Agreement (original signature required);
- Face sheet from current professional/liability policy (must indicate practitioner's name as the insured, policy period and coverage amounts);
- State License/ Certification;
- DEA Certificate (if applicable);
- Protocol for physician oversight of prescribing nurses (if applicable);
- Proof of Board Certification (if applicable);
- Education Commission for Foreign Medical Graduates (ECFMG) Certificate (if applicable);
- Test of English as a Foreign Language (TOEFL) Certificate (if applicable);
- Work History/ Curriculum Vitae / Resume (must include month and year) covering at least the past five (5) years. Any lapse in continuous employment or work history must be fully explained on a separate sheet;
- Current ANCC Board Certification (for RNCS)
- Current Fellow/Diplomate Membership of the American Association of Pastoral Counselors (AAPC)

Please return all materials within 15 days of receipt to:

ValueOptions Provider Relations – Credentialing
P.O. Box 551188
Jacksonville, FL 32255-1188

Please retain a copy of the completed application for reference in case we have questions.

Note: If ValueOptions is unable to secure the requested information, the assumption will be made that network participation is not desired and the application process will be discontinued. If a provider is interested in participation at a later date, re-application will be required.

Providers are asked to keep all demographic information, including fax numbers and email addresses, if applicable, current with ValueOptions at all times, which affects our ability to refer beneficiaries and pay claims.

Should questions arise, please call toll-free, (800) 700-8646 (select option 4, then option 2) between the hours of 8 a.m. and 6 p.m. Eastern time, to speak to a Provider Relations Representative. Questions can also be e-mailed to provhelptricare@jax.valueoptions.com.

► Practitioners have the right to review information submitted in support of their credentialing application. All requests for documentation must be submitted in writing. ValueOptions will not release information obtained through the primary source verification process, when law prohibits disclosure. ValueOptions will not discriminate against any provider seeking to become a Network participating provider.

TRICARE South Region Application

A. PROVIDER INFORMATION

Last Name	Suffix	First Name	Middle Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address Line 1		Mailing Address Line 2 (include suite #)		
City		State	Zip	Telephone: () FAX: ()
Social Security Number		Date of Birth		Professional Designation or Title
NPI for SSN		E-mail address		
Indicate any other name you may have used in the past* (e.g., maiden name, etc.)		U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, alien Registration # _____		Current Military Status: <input type="checkbox"/> Reservist <input type="checkbox"/> Active Duty <input type="checkbox"/> N / A
Credentialing Contact / Telephone Number		Are you a certified TRICARE provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		

COMMUNICATION PREFERENCE: Please indicate your preferred method of communication by noting a 1-2- or 3 under Rank Order with “1” as the primary method. If you only have one preferred method, please indicate N/A on the other methods (*please print legibly*).

RANK ORDER	METHOD <i>(for internal use only)</i>	(Note any changes here if different than noted above)
	Primary Fax #:	
	Primary E-mail Address:	
	Telephone – specify number, if different from that indicated above:	

B. REFERRAL INFORMATION

LICENSED DISCIPLINE: Indicate the discipline under which you are LICENSED and/or CERTIFIED and wish to have credentialed. Only one (1) can be selected.

- | | |
|--|---|
| <input type="checkbox"/> Psychiatrist (26) | <input type="checkbox"/> Social Worker (LISW/LCSW) (A7) |
| <input type="checkbox"/> Addictionologist | <input type="checkbox"/> Licensed Professional Counselor/Mental Health Counselor (93) |
| <input type="checkbox"/> Child Psychiatrist (77) | <input type="checkbox"/> Marriage & Family Therapist (A8) |
| <input type="checkbox"/> Psychologist (62) | <input type="checkbox"/> Pastoral Counselor (A6) |
| <input type="checkbox"/> Psychiatric Nurse (RNCS, APN) (91) | <input type="checkbox"/> Pediatrician (37) |
| <input type="checkbox"/> Nurse Practitioner (ARNP, APN) (90) | <input type="checkbox"/> Family Practice (08) |

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Description of practice:

Population	Percent of Practice		Are You Currently Accepting New Patients?	Modality	Percent of Practice
Child (0-12)	%	⇒	<input type="checkbox"/> Yes <input type="checkbox"/> No	Inpatient	%
Adolescent (13-17)	%	⇒	<input type="checkbox"/> Yes <input type="checkbox"/> No	Outpatient	%
Adult (18-64)	%	⇒	<input type="checkbox"/> Yes <input type="checkbox"/> No	Must equal 100%	
Geriatric (65+)	%	⇒	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Must equal 100%

Primary language spoken, if other than English: _____

Identify any foreign language(s) or sign language that you use fluently in treating patients (select no more than 5 and rank numerically in order of preference):

- | | | | |
|----------------------------------|---------------------|----------------------|------------------------------|
| ____ American Sign Language (SG) | ____ French (FR) | ____ Italian (IT) | ____ Russian (RU) |
| ____ Arabic (AR) | ____ German (GE) | ____ Japanese (JA) | ____ Spanish (SP) |
| ____ Armenian (AN) | ____ Greek (GR) | ____ Korean (KO) | ____ Swedish (SW) |
| ____ Chinese (CH) | ____ Hebrew (HE) | ____ Norwegian (NW) | ____ Tagalog / Filipino (PH) |
| ____ Dutch (DU) | ____ Hindi (HI) | ____ Polish (PL) | ____ Vietnamese (VI) |
| ____ Farsi / Persian (FA) | ____ Hungarian (HU) | ____ Portuguese (PO) | ____ Yiddish (YI) |

ALTERNATE PRACTICE COVERAGE: Please list the practitioners covering your practice when you are unavailable (other than yourself).

Name	Phone #
Name	Phone #

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CLINICAL EXPERTISE (SPECIALTIES): From the list below, rank order a **maximum of five (5) specialty areas** for which you have training and expertise. For example “1” means primary specialty, “2” means secondary specialty, etc. If you indicate more than five (5) specialties, they will not be documented. These specialties will be used to assist ValueOptions in making clinically appropriate referrals (the letters/numbers in parentheses are for internal use).

- | | | |
|---|---|---|
| <input type="checkbox"/> Adolescent Therapy (I4) | <input type="checkbox"/> Chronic Pain (I8) | <input type="checkbox"/> Head Trauma (L4) |
| <input type="checkbox"/> Affective Disorder (I2) | <input type="checkbox"/> Christian Counseling (I7) | <input type="checkbox"/> Neuropsychological Testing (L9) |
| <input type="checkbox"/> Alcohol / Chemical Dependency (I3) | <input type="checkbox"/> Critical Incident Stress Debriefing (N6) | <input type="checkbox"/> Panic/Phobias (M1) |
| <input type="checkbox"/> Anxiety Disorders (Q4) | <input type="checkbox"/> Dissociative Identity Disorders (L8) | <input type="checkbox"/> Physical / Sexual Abuse Victims (M9) |
| <input type="checkbox"/> ASAM Certified Addictionologist (N8) | <input type="checkbox"/> Eating Disorders (J2) | <input type="checkbox"/> Post-Traumatic Stress Disorder (M3) |
| <input type="checkbox"/> Autistic Disorder/Asperger Syndrome (Q5) | <input type="checkbox"/> ECT (J3) | <input type="checkbox"/> Psych Testing (M5) |
| <input type="checkbox"/> ADHD (I1) | <input type="checkbox"/> Family Therapy/Blended Families (J6) | <input type="checkbox"/> Schizophrenia (M7) |
| <input type="checkbox"/> Borderline Personality / Traits (I6) | <input type="checkbox"/> Gay/Lesbian/Bisexual Issues (J9) | <input type="checkbox"/> Separation/Divorce (L6) |
| <input type="checkbox"/> Child Therapy (L2) | <input type="checkbox"/> Grief/Bereavement (K8) | <input type="checkbox"/> Stress Management (N3) |

C. PRIMARY PRACTICE LOCATION

Practice Name			
Practice Address Line 1 (street address required for referral purposes)		Practice Address Line 2 (include Suite #)	
City	State	Zip	Appointment Telephone (include area code)
Office Manager (if applicable)		Fax Number (include area code)	

Billing Name (must match tax ID name on file with IRS for the TIN listed below)			
Billing Address Line 1		Billing Address Line 2	
City	State	Zip	Telephone (include area code)
Tax Identification Number (TIN)		Your Medicare/UPIN Number <input type="checkbox"/> N/A	
Designated Primary Address for NPI		NPI for this TIN	
		Is the NPI the same for SSN and TIN? <input type="checkbox"/> yes / <input type="checkbox"/> no	

A certification signature, from the TIN owner/representative, is required if applicant requests payment to a TIN assigned to another individual, corporation or partnership to authorize payment to the TIN owner, for TRICARE services rendered by applicant.

- N/A TIN is assigned to applicant
- TIN is assigned to another individual or entity

Authorization Signature by TIN Owner / Representative

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Hours of Operation - please check (✓) practice availability each day at **this** location.

(e.g., **morning** = 8:00am to noon; **afternoon** = noon to 5:00pm; **evening** = 5:00 pm or later):

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning						
Afternoon						
Evening						

Is this office handicapped accessible? Yes No Is this office accessible to public transportation? Yes No

ADDITIONAL PRACTICE LOCATIONS

*(If you have **more than three (3)** practice locations please copy these pages before completing)*

Practice Name			
Practice Address Line 1 (street address required for referral purposes)		Practice Address Line 2 (include Suite #)	
City	State	Zip	Appointment Telephone (include area code)
Office Manager (if applicable)		Fax Number (include area code)	

Billing Name (must match tax ID name on file with IRS for the TIN listed below) OR <input type="checkbox"/> Same as for Primary Practice			
Billing Address Line 1		Billing Address Line 2	
City	State	Zip	Telephone (include area code)
Tax Identification Number (TIN)		Your Medicare/UPIN Number <input type="checkbox"/> N/A	
Designated Primary Address for NPI		NPI for this TIN	

A certification signature, from the TIN owner/representative, is required if applicant requests payment to a TIN assigned to another individual, corporation or partnership to authorize payment to the TIN owner, for TRICARE services rendered by applicant.

- N/A TIN is assigned to applicant
- TIN is assigned to another individual or entity

Authorization Signature by TIN Owner / Representative

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Hours of Operation - please check (✓) practice availability each day at **this** location.

(e.g., **morning** = 8:00am to noon; **afternoon** = noon to 5:00pm; **evening** = 5:00 pm or later):

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning						
Afternoon						
Evening						

Is this office handicapped accessible? Yes No Is this office accessible to public transportation? Yes No

ADDITIONAL PRACTICE LOCATIONS

Practice Name			
Practice Address Line 1 (street address required for referral purposes)		Practice Address Line 2 (include Suite #)	
City	State	Zip	Appointment Telephone (include area code)
Office Manager (if applicable)		Fax Number (include area code)	

Billing Name (must match tax ID on file with IRS for the TIN listed below)			
Billing Address Line 1		Billing Address Line 2	
City	State	Zip	Telephone (include area code)
Tax Identification Number (TIN)		Your Medicare/UPIN Number <input type="checkbox"/> N/A	
Designated Primary Address for NPI		NPI for this TIN	

A certification signature, from the TIN owner/representative, is required if applicant requests payment to a TIN assigned to another individual, corporation or partnership to authorize payment to the TIN owner, for TRICARE services rendered by applicant.

- N/A TIN is assigned to applicant
- TIN is assigned to another individual or entity

Authorization Signature by TIN Owner / Representative

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Hours of Operation – please check (✓) practice availability each day at **this** location.

(e.g., **morning** = 8:00am to noon; **afternoon** = noon to 5:00pm; **evening** = 5:00 pm or later):

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning						
Afternoon						
Evening						

Is this office handicapped accessible? Yes No Is this office accessible to public transportation? Yes No

D. EDUCATION INFORMATION (REQUIRED for verification purposes)

Educational Institution (include name and <u>complete</u> address)		Degree	From (mm/yy)	To (mm/yy)
Undergraduate	Institution:			
	Address:			
	City, State, Zip:			
Graduate/ Medical School	Institution:			
	Address:			
	City, State, Zip:			
Internship	Institution:			
	Address:			
	City, State, Zip:			
Residency	Institution:			
	Address:			
	City, State, Zip:			

Fellowship	Institution:			
	Address:			
	City, State, Zip:			

If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? Yes No

If answered yes, please include a copy of your certificate.

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E. LICENSE/CERTIFICATION INFORMATION

DEA CERTIFICATES: List your current DEA certificate number, if applicable. **Be sure to include a current copy of your certificate(s) with your application materials.**

DEA Certificate #	Exp. Date
	/ /

PROFESSIONAL LICENSE(S): Please identify in the list below, **all** health care licenses held in the past ten (10) years. Indicate original licensure date through current expiration date for each state in which you are or have been licensed/certified. Please provide an explanation for any license that is no longer current, whether by voluntary relinquishment, disciplinary or other action. Attach an additional sheet if necessary.

Licensing Board Name	State	Specify Active or Inactive	Certificate #	Original Issue Date (mm/dd/yy)	Expiration Date (mm/dd/yy)
				/ /	/ /
				/ /	/ /
				/ /	/ /

BOARD CERTIFICATION/SPECIALTY (for MDs and DOs only): List below any certifications you have received from any nationally recognized specialty boards.

PRINCIPAL SPECIALTY	Name of Board (if board certified)
Exam Information (check one):	
<input type="checkbox"/> Oral exam taken <input type="checkbox"/> Oral exam scheduled <input type="checkbox"/> Written exam taken <input type="checkbox"/> Written exam scheduled <input type="checkbox"/> No plans to take exam	
Exam Date: / /	Date Certified: / /
Re-exam Date: / /	

SECONDARY SPECIALTY	Name of Board (if board certified)
Exam Information (check one):	
<input type="checkbox"/> Oral exam taken <input type="checkbox"/> Oral exam scheduled <input type="checkbox"/> Written exam taken <input type="checkbox"/> Written exam scheduled <input type="checkbox"/> No plans to take exam	
Exam Date: / /	Date Certified: / /
Re-exam Date: / /	

ADDITIONAL CERTIFICATIONS (for RNCs and PCs only)

Certification Type	Certificate #	Expiration Date (mm/dd/yy)
American Nursing Credentialing Center (ANCC) Board Certification (i.e. APRN, BC)		/ /
Fellow/Diplomate Membership of the American Association of Pastoral Counselors (AAPC)		/ /

Please include a current copy of your certification with your application materials.

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F. MALPRACTICE INSURANCE

List your **current** malpractice carrier below. Enclose a copy of your current policy certificate and/or declarations page indicating **you** as the covered clinician, showing the coverage limits and dates of coverage.

Current Carrier (Name and Certificate Number)	Dates of Coverage From (mm/yy) – To (mm/yy)	Coverage Limits

Has the same carrier covered you for the past five (5) years? Yes No (see next section)

If you have not possessed coverage with the same carrier for the past 5 years, list below the name and complete address of any other malpractice carrier who has provided coverage for you for the most recent five (5) year period. **If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.**

Carrier (Name and Complete Address)	Dates of Coverage From (mm/yy) – To (mm/yy)	Reason for Changing Carriers

Pending and/or settled malpractice claims – Please provide information on all pending and/or settled malpractice claims. Be as specific as possible with regard to procedures, names, dates, and actions. Explanations provided must include the minimum information requested below (you may use the space below or include a separate sheet, as necessary). If you have no pending/settled claims, please mark this section *not applicable* (N/A).

Patient's name:	Date of occurrence (mm/dd/yy):	
Insurance company defending your claim:		
Hospital name:		
Hospital address:		
Procedures performed:		
Co-defendants:		
Court trial? <input type="checkbox"/> Yes <input type="checkbox"/> No	Settlement out of court? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of settlement (mm/dd/yy):
Allegations:		
Claim settled for no payment on your behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is claim pending? <input type="checkbox"/> Yes <input type="checkbox"/> No
Amount in reserve by insurance company:	Total amount paid to claimant on your behalf:	
Total amount paid to claimant for all defendants:		

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G. PROVIDER PROFILE

Please answer all provider profile questions.

NOTE: If **YES** is checked, **please explain fully** on a separate sheet (may use *Malpractice Claim Information Work Sheet* above). Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudications, original complaint and final disposition). The documentation must be from an attorney or the entity that issued the judgment.

1. Health Status: Do you have any physical, mental, or emotional conditions, including but not limited to, a history of drug or alcohol abuse, which may currently impair your ability to render the professional services which are the subject of this application? Currently means recently enough that the condition could reasonably have an impact on your ability to safely and competently render professional services. Yes No
2. Insurance Coverage: Has your professional liability insurance coverage ever been denied, canceled, not renewed or initially refused upon application? Yes No
3. License: Has your medical or professional license in any state ever been revoked, suspended, or placed on probation, conditional status, or limited? Yes No
 - a. Have you ever voluntarily surrendered your license? Yes No
 - b. Are formal charges pending against you at this time? Yes No
4. DEA: Has your DEA Registration Certificate ever been suspended, revoked, subjected to probation, placed on conditional status, or limited? Yes No
5. Hospital Privileges: Has any hospital ever dismissed you from its staff? Yes No
 - a. Has any hospital ever revoked, suspended, or limited your privileges? Yes No
 - b. Has any hospital initiated either type of the aforementioned action by formal notice to you? Yes No
 - c. Has any hospital refused or denied you privileges? Yes No
 - d. Have you ever voluntarily surrendered your hospital privileges? Yes No
6. Hospital Sanctions: Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension or revocation of such privileges? Yes No
7. Professional Membership(s): Has your membership in any professional society or association ever been canceled, revoked, or censured? Yes No
8. Medicare/Medicaid/TRICARE: Have you ever been fined, had an arrangement suspended, been expelled from participation in or had criminal charges brought against you by any Medicare, Medicaid, or TRICARE program?..... Yes No
9. Criminal Offenses: Have you ever been arrested, charged with or convicted of a felony or involved in charges relating to moral or ethical turpitude, including crimes involving children or illegal drug use? Yes No
 - a. Are you currently engaged in the illegal use of drugs? Yes No
 - b. Have you ever been named as a defendant in any criminal proceeding? Yes No
10. Board Discipline: Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county, state or national professional society; hospital medical or clinical staff)? Yes No
11. Malpractice Action: Has any malpractice action against you been brought or settled in the past 5 years or have there been any unfavorable judgments against you in a malpractice action? Yes No
 - a. To your knowledge, is there any malpractice action currently pending against you? Yes No
 - b. If your answer to question 11 above is yes, please indicate the number of malpractice claims pending and/or closed: One (1) Two (2) More than 2 (specify number: _____)
 - c. Have you ever been a defendant in any lawsuit involving your practice where there has been an award or payment of \$100,000 or more? Yes No
 - d. Have you had any malpractice claims where there has been an award or payment of \$100,000 or more? Yes No

- end of Provider Profile questions -



TRICARE South Region Application
ATTESTATION/PARTICIPATION STATEMENT

I fully understand that this application is being signed under penalty of perjury and I am subject to the applicable federal punishment for perjury. I further understand that if any information supplied as part of this application process is or becomes false, *ValueOptions* is entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true, correct and complete.

I authorize *ValueOptions* and its Credentialing Verification Organization (CVO) to consult with the National Practitioner Data Bank, state licensing board(s), educational institutions, including medical and graduate schools, and places of residency training, specialty boards, malpractice insurance carriers, Education Commission for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character, and moral and ethical qualifications, and I also authorize all of them to release such information to *ValueOptions and its CVO*. I release *ValueOptions and its CVO* and its employees and agents and all those whom *ValueOptions and its CVO* contacts, from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to *ValueOptions and its CVO* all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualifications, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

I certify that there are no physical or mental contraindications to my delivery of appropriate patient care within my designated scope of practice.

I understand that Federal Law (5 U.S.C. 5536) prohibits medical personnel who are active duty members or civilian employees of the government from being TRICARE/CHAMPUS providers. 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 where either a uniformed member or civilian employee of the uniformed 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. I certify that I am not an active duty member or civilian employee of the government.

I understand that *ValueOptions* may be required by the Federal government to perform a criminal records check as a condition for participation and that *ValueOptions* has the right to obtain a copy of a criminal history report and share such record with the TRICARE Management Activity (TMA). I also understand that I have the right to challenge the accuracy and completeness of any information contained in such a report.

ValueOptions will not discriminate against any provider seeking qualification as a Network participating provider.

 Signature of Applicant

Date (mm/dd/yy): ____/____/____

 Printed Name of Applicant

 Social Security Number

TRICARE South Region Application**ValueOptions Criminal History Background Check Form**

ValueOptions is required to conduct a criminal history background check. Please complete the following information that will be submitted to the county and state in which you live for criminal history information.

This form must be completely filled out.

Please include this form when submitting your application to ValueOptions.

Last Name: _____

First Name & M.I.: _____

Social Security Number: _____

Date of Birth: _____

Aliases or Previous Names: _____

Drivers License Number/State: _____

Current Home Address: _____

City, State: _____

County and Zip Code: _____

Dates of Residence: **From:** _____ **To:** _____

Previous Home Address:
(if less than 5 yrs @ current address) _____

City, State: _____

County and Zip Code: _____

Dates of Residence: **From:** _____ **To:** _____

I fully understand that ValueOptions may be required by the Federal government to perform a criminal record check as a condition for participation and that ValueOptions has the right to obtain a copy of a criminal history report and share such record with TRICARE. I also understand that I have the right to challenge the accuracy and completeness of any information contained in such request.

Please Sign Here: _____