CORPORATE SERVICES PROVIDER
APPLICATION FOR TRICARE PROVIDER STATUS

OMB No. 0720-0020
OMB approval expires
20221031

The public reporting burden for this collection of information, 0720-0020, 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 revewing the collection of infromation. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. 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 nnumber.

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:

1. Provider Name

2. Provider Certification (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.

a. Signature of Chief Executive Officer	b. Date

3. Institution/ Corporate Services Provider Identification Information

a. Name

b. Corporate/Foundation Name (If different)

c. Address (Physical Location) (Street, City, State and ZIP Code)	d. Mailing Address (If different)

e. Telephone Number (Include Area Code)	f. Facsimile Number (Include Area Code)	g. Tax ID Number

h. Are you a Medicare Provider? ☐ YES ☐ NO (If yes:)

(1) Medicare Certification Number	(2) Medicare Category	(3) Medicare Acceptance Date

i. Are you JCAHO accredited? ☐ YES ☐ NO (If yes:)

(1) JCAHO Classification	(2) Original JCAHO Classification Date	(3) Current JCAHO Classification Dates	
		FROM:	TO:

j. State License Classification	k. Dates of State Licensure	
	FROM:	TO:

l. Are you Certified by a national board? ☐ YES ☐ NO (If yes:)

(1) Name of Board	(2) Effective Date of Certification

IMPORTANT: Please attach copies of applicable Medicare, JCAHO, State, and National Board Certificates/Licenses.