CORPORATE SERVICES PROVIDER
APPLICATION FOR TRICARE PROVIDER STATUS

OMB No. 0720-0020
OMB approval expires 20251130

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 *(YYYYMMDD)*

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 *(YYYYMMDD)*

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

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

j. State License Classification	k. Dates of State Licensure *(YYYYMMDD)* FROM:	TO:

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

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

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