

TRICARE OVERVIEW

TRICARE is the health care program for active duty and retired members of the uniformed services, their families, and survivors. TRICARE's primary objectives are to optimize the delivery of health care services for all Military Health System beneficiaries and attain the highest level of patient satisfaction through the delivery of a world-class health care benefit. This is accomplished through the use of three TRICARE regions. Nebraska is currently located in the West Region and is administered by TriWest Healthcare Alliance. In an effort to provide local representation and expertise, TriWest has subcontracted the network development and maintenance activities to each of its network subcontractors. Nebraska's subcontractor is Blue Cross and Blue Shield of Nebraska (BCBSNE).

BCBSNE will credential you as a TRICARE network provider. In order to do so we will need page 2 signed and dated and returned with the universal application for BCBSNE. **Please respond to the military question.**

If you are one of the specialties listed on page 3, please fill out the appropriate area of interest and return also.

MENTAL HEALTH PRACTITIONERS

If you are a behavioral health provider please fill out page 4 and there are additional attestations that will need to be signed. Please sign and date all that are appropriate to your practice. If you have more than one licensure, **please verify which your primary practice specialty is _____**. TriWest has specific restrictions for practicing as an LMHP and fewer restrictions for Social Work and Marriage Family Therapists. Please contact Ruth Gahan for any questions regarding your practice.

Your TRICARE Network Consultant is Ruth Gahan RN. Please contact her with any questions regarding TRICARE at 402-343-3517 or 1-800-821-4787 options #1, #5.

FOR TRICARE

**CONSENT TO THE INSPECTION OF RECORDS AND DOCUMENTS
RELEASE OF INFORMATION AND LIABILITY**

I, _____ hereby authorize TRIWEST HEALTHCARE ALLIANCE- its professional staff and legal representatives for the purpose of evaluating my professional competence, character, criminal history and ethical conduct, to contact and consult with administrators and members of the professional staff of any treatment facility, institution, professional society, school, employer, law enforcement agency, or practice with which I have been associated. In addition, I consent to the inspection by TRIWEST HEALTHCARE ALLIANCE -its professional staff and legal representatives of all records and documents, including health records at other treatment facilities that may be material for evaluation of my professional qualifications. I also release from liability all individuals or organizations for their acts performed in good faith and without malice who honestly initiate and respond to the inquiries authorized for use by TRIWEST HEALTHCARE ALLIANCE. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Signature

Date

MILITARY INFORMATION

Are you subject to mobilization as a member of a reserve or Guard unit, as an individual mobilization augmentee, or subject to recall to active duty as a retired military provider? Yes No

If Yes to above, which Service Status applies? (Check one)

Which Service Branch applies? (Check one)

Active Reserve
Active National Guard
Retired Reserve
Retired Regular
Retired National Guard

US Army
Army National Guard
US Air Force
Air National Guard
US Navy
US Coast Guard
US Marine Corp

Provider Practice Focus Medical/Surgical

Date: _____

Name: _____

Please identify what age groups you provide services for:

- 0-5 6-12 13-17 18-65 65+

Please check those areas in which you focus your practice. These may or may not be covered benefits.

DENTAL:

- TMJ

DERMATOLOGY:

- MOHS only

OPHTHALMOLOGY:

- Cataract Laser Surgery
- Cornea Specialist
- Glaucoma Specialist
- Oculoplastics
- Orbit Specialist
- Retinal Specialist
- Strabismus Specialist

ORTHOPEDICS:

- Hip Surgery
- Joint Replacement
- Knee Surgery
- Shoulder Surgery

The information provided on this form will only be used to direct beneficiaries to providers that focus on the above areas. This information is not credentialed, validated or verified in any way.

Provider Practice Focus Behavioral Health

Date: _____

Name: _____

Please identify what age groups you provide services for:

- 0-5
 6-12
 13-17
 18-65
 65+

**Please check those capabilities in which you focus your practice.
These may or may not be covered benefits.**

- | | | |
|--|--|---|
| <input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Addictions
<input type="checkbox"/> Adoption Issues
<input type="checkbox"/> Anxiety Disorder
<input type="checkbox"/> Behavior Modification
<input type="checkbox"/> Bi-Polar Disorder
<input type="checkbox"/> Biofeedback
<input type="checkbox"/> Child Abuse
<input type="checkbox"/> Christian Counseling
<input type="checkbox"/> Chronic Mental Illness
<input type="checkbox"/> Chronic Physical Illness
<input type="checkbox"/> Co-dependency
<input type="checkbox"/> Compulsive Gambling
<input type="checkbox"/> Conduct/Disruptive Disorders
<input type="checkbox"/> Couples/Marriage Therapy
<input type="checkbox"/> Crisis Intervention Svcs
<input type="checkbox"/> Critical Incident Debriefing
<input type="checkbox"/> Depressive Disorder
<input type="checkbox"/> Developmental Disabilities
<input type="checkbox"/> Disability Evaluation
<input type="checkbox"/> Dissociative Disorder
<input type="checkbox"/> Divorce
<input type="checkbox"/> Domestic Violence
<input type="checkbox"/> Dual Diagnosis
<input type="checkbox"/> Eating Disorders
<input type="checkbox"/> Electro-Convulsive Therapy (ECT) | <input type="checkbox"/> Family Therapy
<input type="checkbox"/> Forensic/Sex Offenders
<input type="checkbox"/> Gay/Lesbian
<input type="checkbox"/> Grief Counseling
<input type="checkbox"/> Gender Identity
<input type="checkbox"/> Group Therapy
<input type="checkbox"/> Head Injury Patients
<input type="checkbox"/> Hearing Impaired issues
<input type="checkbox"/> HIV Positive/AIDS Patients
<input type="checkbox"/> Home Based Services
<input type="checkbox"/> Home Care/Home Visits
<input type="checkbox"/> Hypnosis
<input type="checkbox"/> Infertility
<input type="checkbox"/> Learning Disabilities
<input type="checkbox"/> Medical Stress/Behavioral Med
<input type="checkbox"/> Medication Management
<input type="checkbox"/> Men's Issues
<input type="checkbox"/> Mood Disorders
<input type="checkbox"/> Multicultural Issues
<input type="checkbox"/> Neuropsych Assessment
<input type="checkbox"/> Obsessive Compulsive Disorder
<input type="checkbox"/> Organic Brain Syndrome
<input type="checkbox"/> Organic Disorders
<input type="checkbox"/> Pain Management
<input type="checkbox"/> Panic Disorder
<input type="checkbox"/> Parenting Skills | <input type="checkbox"/> Pastoral Counseling
<input type="checkbox"/> Personality Disorder
<input type="checkbox"/> Phobias
<input type="checkbox"/> Physical Abuse/Violence
<input type="checkbox"/> Physically Impaired Patients
<input type="checkbox"/> Play Therapy
<input type="checkbox"/> Police Personnel
<input type="checkbox"/> Post Traumatic Stress Disorder
<input type="checkbox"/> Psych. Disability Eval/Mgmt
<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Psychosomatic
<input type="checkbox"/> Psychotic Disorders
<input type="checkbox"/> Rape Victims
<input type="checkbox"/> Schizophrenic Disorders
<input type="checkbox"/> Sex Offender
<input type="checkbox"/> Sexual Abuse/Violence
<input type="checkbox"/> Sexual Dysfunction
<input type="checkbox"/> Sexual Harassment
<input type="checkbox"/> Sleep Disorders
<input type="checkbox"/> Somatoform Disorders
<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Terminally Ill Patients
<input type="checkbox"/> Visually Impaired Patients
<input type="checkbox"/> Women's Issues |
|--|--|---|

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