

TRICARE Supplemental Questions

Date: _____ Provider Name: _____

Physical Address: _____

City, State, Zip code: _____

I. Provider Capability/Services

Please identify what age and gender groups you provide services for (check all that apply)

- Preschool 0-5
- Children 6-12
- Adolescent 13-17
- Adults 18-65
- Geriatrics 65+
- Male patients
- Female patients

Please check those capabilities in which you are certified or have received specific or on-going training. These may or may not be a covered benefit.

Dental:

- TMJ

Dermatology:

- MOHS Surgery only

Infectious Disease:

- HIV

Neurology:

- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis (ALS)
- Epilepsy
- Huntington's Disease
- Memory Loss
- Parkinson's Disease

Obstetrics/Gynecology

- High Risk OB/Pregnancy

Ophthalmology:

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

Pain Management:

- Short Term Pain Management

Radiology:

- Professional Services
- Ultrasound Only

Speech Pathology:

- Autism (speech)
- Developmental Disabilities

Surgery (Orthopedic):

- Arthroscopic Surgery
- Elbow Surgery
- Foot and Ankle Surgery
- Hip Surgery
- Joint Replacement
- Knee Surgery
- Shoulder Surgery
- Wrist Surgery

Surgery (Other):

- Bariatric Surgery
- Breast Surgery
- Gastric Banding

Other:

- EMG
- Sleep Studies
- Sleep Study Prosthetics
- Telemedicine Services
- Urodynamics
- Venous Closures

II. Military Status

- 1) Are you an Active Duty Service Member (ADSM)? Yes No
- 2) Are you currently employed at Military Treatment Facility (MTF)? Yes No
- 3) In the past twelve (12) months have you been employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly for decisions regarding Department of Defense payments? Yes No

Signature

Date Signed