

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

Ophthalmology:

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

Surgery (Orthopedic):

- Arthroscopic Surgery
- Elbow Surgery
- Hip Surgery
- Joint Replacement
- Knee Surgery
- Shoulder Surgery
- Wrist Surgery

Surgery (Other):

- Bariatric Surgery
- Gastric Banding

Other:

- Epilepsy
- Sleep Study
- Prosthetics
- Ultrasound Only
- Urodynamics
- Venous Closures

II. Military Status

- 1) Are you an Active Duty Service Member (ADSM)? Yes No
- 2) Are you currently employed at a 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