Certified Labor Doula (CLD) provider certification application

Required:

Name: _____

Practitioner NPI #: _____

For information on certification requirements, refer to the *TRICARE Operations Manual (TOM), Ch. 18, Sec. 11*

Applicant information. All fields are required.

First name: _____ Middle initial: _____ Last name: _____

Suffix: _____ ☐ Female ☐ Male National Provider Identifier (NPI) #: _____

SSN: _____ Date of birth (mm/dd/yyyy): _____

Email address: _____ *Note: applicant must be at least 18 years old to qualify as a CLD*

Practice information. All fields are required.

Tax Identification Number (TIN): _____ Practice NPI #: _____

Legal practice name: _____

Practice DBA name: _____

Practice location address (no PO Box): _____

Practice location address line 2 (suite/other): _____

City: _____ State: _____ ZIP: _____

Practice phone #: (____)_____ Practice fax #: (____)_____

Billing address: ☐ Same as practice address

Billing address line 1: _____

Billing address line 2: _____

City: _____ State: _____ ZIP: _____

Billing phone #: (____) _____ Billing fax #: (____) _____

Correspondence address to mail notification: ☐ Same as practice address ☐ Same as billing address

Correspondence address line 1: _____

Correspondence address line 2: _____

City: _____ State: _____ ZIP: _____

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State licensure/certification

If a state or local jurisdiction offers a doula, childbirth support, or similar licensure or certification the provider shall maintain such license or certification, even if it is optional in the state or local jurisdiction. **(Copy of licensure/certification must be enclosed.)**

☐ Temporary/Limited ☐ Permanent ☐ My state does not offer licensure/certification

License/Certification #: _____ Issuing state: _____

Date license was first issued (mm/dd/yyyy): _____ Expiration date (mm/dd/yyyy): _____

License/Certification specialty: _____

Do you have any disciplinary actions/sanctions against your license/certification?

☐ Yes. If yes, you must include a signed, detailed explanation ☐ No

National board certification

The CLD must have a current certification as a CLD, certified doula, or similar perinatal certification (**postpartum doula certification by itself does not qualify**), obtained within the last three years from one of the organizations below considered. **(Copy of certification must be enclosed.)**

☐ I am certified by BirthWorks International as a Birth Doula

☐ I am certified by the Childbirth and Postpartum Professional Association (CAPPA) as a CLD

☐ I am certified by Doulas of North America (DONA) International as a Birth Doula

☐ I am certified by the International Childbirth Education Association (ICEA) as an ICEA Certified Birth Doula (ICBD)

☐ I am certified by ToLabor as a Certified Professional Birth Doula

☐ I am certified by National Black Doulas Association (NBDA) as a Birth Doula

National board certification #: _____

Effective date (mm/dd/yyyy): _____ Expiration date (mm/dd/yyyy): _____

☐ I am **not** certified by one of the organizations listed above and will provide information about my participation in a Medicaid program below.

Medicaid participation *Note: This section is only required for CLDs without a national board certification.*

Participation in a Medicaid doula program may be substituted for the national board certification requirement for CLDs practicing in states with an active statewide doula Medicaid benefit. Participation must be in a permanent statewide Medicaid doula program, excluding geographically or time limited programs and programs with requirements set by affordable care or managed care organizations. The Medicaid participation must remain active and in the same practicing state to be TRICARE- authorized. (Copy of Medicaid approval letter must be enclosed.)

Do you participate in a permanent statewide Medicaid doula program? ☐ Yes ☐ No

State: _____ Medicaid #: _____ Medicaid acceptance date (mm/dd/yyyy): _____

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Certified Pulmonary Resuscitation (CPR) certification

CLDs are required to maintain a current adult, child and infant CPR certification. Basic Life Support (BLS) certification is also acceptable. **(Copy of CPR certificate must be enclosed.)**

CPR/BLS issuing organization: _____

CPR/BLS certification # (as applicable): _____

CPR/BLS issue date (mm/dd/yyyy): _____ CPR/BLS expiration date (mm/dd/yyyy): _____

Education and experience requirements:

☐ I understand the childbirth of an immediate family member, a CLD's own childbirth or childbirth course attendance in the course of the CLD's own pregnancy/pregnancy of a partner shall not count towards the training, education, or experience requirements listed below.

☐ I attest I have attended a minimum of 24 education hours, where the following was covered:

- The physiology of labor; and
- Labor doula training; and
- Antepartum doula training; and
- Postpartum doula training.

Note: Self-paced learning such as reading a book or writing an essay is not acceptable; however, remote synchronous or asynchronous online courses or in-person courses are acceptable.

☐ I attest I have attended one or more breastfeeding courses

☐ I attest I have attended one or more childbirth classes

☐ I attest, that within the last three years, I have provided continuous in-person childbirth support for at least three childbirths as the primary labor doula supporting the birthing parent, with a minimum of 15 hours over the three childbirths. At least two of the three births were a vaginal birth.

☐ I attest, that within the last three years, I have provided antepartum and postpartum support for at least one birth.

Dual compensation/Conflict of interest statement for TRICARE providers:

Federal law (5 U.S.C. 5536) prohibits medical personnel, who are active duty members or civilian employees of the government, compensation above their normal pay and allowances for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. Claims for TRICARE benefits will be denied in any situation where either a uniform member or civilian employee of the uniform services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selective basis.

Are you: Employed by the US government? ☐ Yes ☐ No

Providers employed or under a contract which provides for payment to the individual professional provider by an institutional provider cannot be considered. Employees reimbursed by the hospital/institution are not eligible for separate reimbursement outside the realm of the hospital.

Are you: Hospital-salaried/employed? ☐ Yes ☐ No

TRICARE policy (32 CFR 199.6) states that individual health care professionals who are allowed to render health care services only under direct and ongoing supervision as training to be credited towards earning a clinical academic degree or other clinical credential required for the individual to practice independently are excluded from TRICARE participation for the duration of such training.

Are you: In an educational or training program required for your provider type? ☐ Yes ☐ No

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Certified Labor Doula (CLD) provider participation agreement

Required:

Name: _____

Practitioner NPI #: _____

In order to receive payment under TRICARE, _____
DBA _____, as the provider of services agrees:

1. Not to charge a beneficiary for the following:
    a. Services for which the provider is entitled to payment from TRICARE;
    b. Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements;
    c. Services not medically necessary and appropriate for the clinical management of the presenting illness, injury, disorder or maternity;
    d. Services for which a beneficiary would be entitled to payment but for a reduction or denial in payment as a result of quality review; and
    e. Services rendered during a period in which the provider was not in compliance with one or more conditions of authorization:
2. To comply with applicable provisions of 32 CFR 199 and related TRICARE policy;
3. To accept the TRICARE determined allowable payment combined with the cost-share, deductible, and Other Health Insurance (OHI) amounts payable by, or on behalf of, the beneficiary, as full payment for TRICARE-allowed services;
4. To collect from the TRICARE beneficiary those amounts that the beneficiary has a liability to pay for the TRICARE deductible and cost-share/co-payment;
5. To permit access by the Director, Defense Health Agency (DHA), or designee, to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state or private agencies or organizations;
6. To provide to the Director, DHA, or designee (e.g., Contractor), prompt written notification of the provider's employment of an individual who, at any time during the twelve months preceding such employment, was employed in an managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly, for decisions regarding Department of Defense payments to the provider;
7. To cooperate fully with a designated utilization and clinical quality management organization, which has a contract with the DoD for the geographic area, in which the provider renders services;
8. Comply with all applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/co-payment may be expected;
9. To maintain clinical and other records related to individuals for whom TRICARE payment was made for services rendered by the provider, or otherwise under arrangement, for a period of 60 months from the date of service;

To maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, the methods, modalities or means of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment;
Clinical records are required to document the outcomes of standardized assessment measures for PTSD, GAD, and MDD using the PTSD Checklist (PCL), GAD-7, and Patient Health Questionnaire (PHQ)-8, respectively, at baseline, at 60-120 day intervals, and at discharge (See Ch. 1, Sec. 5.1 for details);

11. To refer TRICARE beneficiaries only to providers with which the referring provider does not have an economic interest, as defined in 32 CFR 199.2;

12. To limit services furnished under arrangement to those for which receipt of payment by the TRICARE-authorized provider discharges the payment liability of the beneficiary; and

13. Notify the referring military provider or military hospital or clinic/eMSM referral management office (on behalf of the military provider) when a Service member or beneficiary, in the provider's clinical judgment, meets any of the following criteria:
    a. Harm to self – The provider believes there is a serious risk of self-harm by the Service member either as a result of the condition itself or medical treatment of the condition;
    b. Harm to others – There is a serious risk of harm to others either as a result of the condition itself or medical treatment of the condition. This includes any disclosures concerning child abuse or domestic violence;
    c. Harm to mission – There is a serious risk of harm to a specific military operational mission. Such a serious risk may include disorders that significantly impact impulsivity, insight, reliability and judgment;
    d. Inpatient care – Admitted or discharged from any inpatient mental health or substance use treatment facility as these are considered critical points in treatment and support nationally recognized patient safety standards;
    e. Acute medical conditions interfering with duty – Experiencing an acute mental health condition or is engaged in an acute medical treatment regimen that impairs the beneficiary's ability to perform assigned duties;
    f. Substance abuse treatment program – Entered into, or is being discharged from, a formal outpatient or inpatient treatment program.

14. Meet such other requirements as the Secretary of Defense may find necessary in the interest of health and safety of the individuals who are provided care and services.

DHA agrees to:

Pay the above-named provider the full allowable amount less any applicable double-coverage, cost-share/co-payment and deductible amounts.

This agreement shall be binding on the provider and DHA upon acceptance by the executive director, DHA or designee. This agreement shall be effective until terminated by either party. The effective date shall be the date the agreement is signed by DHA.

This agreement may be terminated by either party by giving the other party written notice of termination. The provider shall also provide written notice to the public. Such notice of termination is to be received by the other party no later than 45 days prior to the date of termination. In the event of transfer of ownership, this agreement is assigned to the new owner, subject to the conditions specified in this agreement and pertinent regulations.

For provider of services by:

Provider name: _____

Phone: _____ Email: _____

Signature of provider: _____

For DHA by:

Name: _____ Title: _____

Signature: _____ Executed on date: _____

Please return participation agreement to: Fax: (844) 684-7461

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Name: _____

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Contact Information

Point of Contact (POC) information if additional information is needed (may be practitioner or group representative)

Name: _____

Title: _____ Phone: _____ Email: _____

I certify that all of the above information is true and correct to the best of my knowledge. I also understand that I must include copies of all attachments listed below in order for my application to be considered. Incomplete or missing information will result in reject of the certification application.

☐ Completed and signed application

☐ Licensure and signed explanation(s) (as applicable)

☐ National Board certification (as applicable)

☐ Medicaid approval letter (as applicable)

☐ CPR/BLS certificate

☐ Completed, signed participation agreement

Signature of provider (electronically signed by):_____ Date: _____

Please return application with attachments by fax to: (844) 684-7461

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