

TRICARE
Areas of Interest (AOI)
Behavioral Health
Provider Capability Form

Date: _____ Provider Name: _____

Physical Address: _____

City, State, Zip Code: _____

Please identify what age and gender groups you provide services for:

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

<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 Services <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"/> Neuro Psych Assessment <input type="checkbox"/> Obesity Assessment/Counseling <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"/> TELEHEALTH <input type="checkbox"/> Distant Site (Provider) <input type="checkbox"/> Originating Site (Patient) <input type="checkbox"/> Terminally Ill patients <input type="checkbox"/> Visually Impaired patients <input type="checkbox"/> Women's Issues <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____
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