



TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039
Fax 803-462-3986

Toll-Free: 1-800-403-3950

TRICARE PROVIDER FILE APPLICATION
CLINIC OR GROUP PRACTICE
PROFESSIONAL ASSOCIATION, CORPORATION, PARTNERSHIP, CLINIC, ETC

GROUP NAME: _____ NPI # _____

FEDERAL TAX NUMBER: _____ TELEPHONE: (____) _____ - _____

Office Location (Street Address): _____ Billing Address (If different): _____

NOTE: If you use a billing agency, please designate telephone number for billing inquiries: _____

Date legal entity established ____/____/____

Are group members all the same specialty? ___ YES ___ NO
If YES, name specialty: _____

Will each Physician sign their own claim form ___ YES ___ NO
IF NO, EACH PHYSICIAN MUST COMPLETE THE ATTACHED SIGNATURE
AUTHORIZATION FORMS AND HAVE THEM NOTARIZED.

Do you use a Patient Account Number? ___ YES ___ NO

Do you currently file claims electronically to PGBA, LLC? ___ YES ___ NO If YES,
Terminal Number _____

IMPORTANT: ALL GROUP MEMBERS MUST COMPLETE AN INDIVIDUAL
APPLICATION AND A REASSIGNMENT OF BENEFITS FORM.

PLEASE complete one application for EACH location.





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ATTACH A PHOTOCOPY OF YOUR LICENSE OR CERTIFICATION

License No: _____ Issuing State: _____

Original License Date: _____

Current License Effective Dates: From _____ To _____

CONFLICT OF INTEREST STATEMENT

“Federal Law (5 U.S.C. 5536) prohibits medical personnel who are active duty members or civilian employees of government from receiving additional government compensation above their normal pay and allowance 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 where either a uniformed member or civilian employee of the uniformed 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.”

Signature of Applicant

Signature Date

“I, the undersigned provider, in submitting this application for certification as an authorized provider under the TRICARE program, do affirm and attest that the information which I have provided in response to and support of this application is true and correct. I understand that any misrepresentation of my credentials which bear upon my qualification for authorized TRICARE provider status may be subject to the Administrative Remedies for Fraud, Abuse and Conflict of Interest as defined in 32 CFR 199.9.”

Signature of Applicant

Signature Date

Please notify Provider Certification of any changes related to your provider file information (name, address, specialty, tax number, group affiliations, etc.).





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GROUP MEMBER LISTING

Please list all of the MEDICAL DOCTORS (MD'S) and OSTEOPATHS (DO'S) affiliated with your group.

PLEASE COMPLETE ALL REQUIRED INFORMATION AND RETURN WITH COPY OF PROFESSIONAL LICENSES, COVER LETTER AND APPLICATION.

PHYSICIAN NAME (LAST, FIRST, MID)	SSN AND NPI NUMBERS	LICENSE NUMBER	PRIMARY SPECIALTY	DATE MD/DO JOINED GRP
1. _____	_____/_____ (SSN / NPI)	_____	_____	_____
	ORIGINAL LICENSE DATE: __/__/__	CURRENT LICENSE DATES: __/__/__ TO __/__/__		
2. _____	_____/_____ (SSN / NPI)	_____	_____	_____
	ORIGINAL LICENSE DATE: __/__/__	CURRENT LICENSE DATES: __/__/__ TO __/__/__		
3. _____	_____/_____ (SSN / NPI)	_____	_____	_____
	ORIGINAL LICENSE DATE: __/__/__	CURRENT LICENSE DATES: __/__/__ TO __/__/__		
4. _____	_____/_____ (SSN / NPI)	_____	_____	_____
	ORIGINAL LICENSE DATE: __/__/__	CURRENT LICENSE DATES: __/__/__ TO __/__/__		
5. _____	_____/_____ (SSN / NPI)	_____	_____	_____
	ORIGINAL LICENSE DATE: __/__/__	CURRENT LICENSE DATES: __/__/__ TO __/__/__		
6. _____	_____/_____ (SSN / NPI)	_____	_____	_____
	ORIGINAL LICENSE DATE: __/__/__	CURRENT LICENSE DATES: __/__/__ TO __/__/__		
7. _____	_____/_____ (SSN / NPI)	_____	_____	_____
	ORIGINAL LICENSE DATE: __/__/__	CURRENT LICENSE DATES: __/__/__ TO __/__/__		
8. _____	_____/_____ (SSN / NPI)	_____	_____	_____
	ORIGINAL LICENSE DATE: __/__/__	CURRENT LICENSE DATES: __/__/__ TO __/__/__		

PLEASE PHOTOCOPY THIS FORM IF YOU HAVE MORE THAN EIGHT PHYSICIANS IN YOUR GROUP.





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SECTION E

_____ I am a licensed registered nurse and I have at least a master's degree in nursing with a specialization in psychiatric and mental health nursing (ATTACH COPY OF DEGREE):

NAME OF SCHOOL: _____

DEGREE: _____ DISCIPLINE: _____ YEAR GRADUATED: _____

ATTACH COPY OF RN LICENSE AS WELL AS PSYCHIATRIC AND MENTAL HEALTH NURSING ASSOCIATION ACCREDITATION.

_____ I have had at least two (2) years of post-master's degree practice in the field of psychiatric and mental health nursing including an average of eight (8) hours of direct patient contact per week. Date experience requirement was met: ____/____/____

OR

_____ I am listed in a TRICARE-recognized, professionally sanctioned listing of clinical specialists in psychiatric and mental health nursing.



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PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

STATE OF _____ COUNTY OF _____

Know all persons by these presents:

That I, _____ have made, constituted and appointed and by these presents do make, constitute and appoint _____ (Please attach a list of any other authorized representatives) my true and lawful attorney-in-fact for me and in my name, place and stead to sign my name on claims, for payment for services provided by me submitted to TRICARE. My signature by my said attorney-in-fact includes my agreement to abide by the TRICARE payment system concept and the remainder of the certification appearing on all TRICARE claim forms. I hereby ratify and confirm all that my said attorney-in-fact shall lawfully do or cause to be done by virtue of the power granted herein.

In witness whereof I have hereunto set my hand this _____ day of _____ 20____.

SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____ 20____

NOTARY PUBLIC IN AND FOR

COUNTY OF _____ STATE OF _____

(SEAL) MY COMMISSION EXPIRES ____/____/____

Per TRICARE Management Activity (TMA) guidelines, we may accept, in lieu of a provider's actual signature on a TRICARE claim form, a facsimiles signature or signature of a representative if the FI has on file a notarized authorization from the provider for use of a facsimile signature or a notarized authorization of power of attorney for another person to sign on his or her behalf.

The authorized representative may sign using the provider's name followed by the representative's initials or using the representative's own signature followed by "POA" (Power of Attorney), or similar indication of the type of authorization granted by the provider.





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PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

STATE OF _____

COUNTY OF _____

_____ being first duly sworn, deposes and says: I hereby authorize the TRICARE Management Activity to accept my facsimile or stamp signature shown below as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the full-payment concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

SIGNATURE

FACSIMILE OR STAMP SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____ 20____

NOTARY PUBLIC IN AND FOR

COUNTY OF _____ STATE OF _____

(SEAL)

MY COMMISSION EXPIRES ____/____/____

Per TMA guidelines, we may accept, in lieu of a provider's actual signature on a TRICARE claim form, a facsimile signature or a signature of a representative if the FI has on file a notarized authorization from the provider for use of a facsimile signature or a notarized authorization of power of attorney for another person to sign on his or her behalf.

The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim form is computer-generated.





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PHYSICIAN AUTHORIZATION FOR REASSIGNMENT OF BENEFITS TO CLINIC

TRICARE
PGBA, LLC

It is agreed that _____
(Name of Clinic, Group or Professional Association)

will bill for and receive any charges or fees for the services of

(Name of Provider)

(Office Address)

Signature-Authorized Individual for Clinic

Signature of Provider

Employer Identification Number

Social Security Number

NPI# for Employer Identification Number

NPI# for Social Security Number

Date

Date

Date individual joined group practice: _____

Please return to the address indicated at the top of this letter.





TERMS AND CONDITIONS FOR ELECTRONIC FUNDS TRANSFER

By Signing below your company agrees to accept payment by PGBA, LLC (PGBA) through electronic funds transfer (EFT). Additionally, you acknowledge and agree that all payments shall be made in accordance with the information that you supply on the Electronic Funds Transfer Authorization Form and that PGBA shall be entitled to rely exclusively upon such information. This agreement applies to and amends all existing agreements with PGBA by incorporating the following terms and conditions for electronic payment. PGBA will initiate payment to you based on the following:

1. PGBA will transfer funds electronically to the financial institution and account number you register on the attached EFT/ERA Enrollment Form.
2. PGBA will make payments in accordance with and be governed by the National Automated Clearinghouse Association's Corporation Trade Payment Rules. Our process is governed by and in accordance with the laws, other than choice of law provision of any particular contract, of South Carolina, including Article 4A of the Uniform Commercial Code as enacted by South Carolina and amended from time to time.
3. The information you provide on the EFT/ERA Enrollment Form is very important. PGBA shall not be liable for any loss which may arise solely by reason of error, mistake, or fraud regarding this information. **You understand that you must communicate any change in this information to PGBA. This communication must be in the form of a new EFT ERA Enrollment Form faxed to this number:**

PGBA, LLC EFT
Fax: 803-462-3995

4. Payment is initiated within the normal terms of our agreement with you and/or applicable TRICARE procedures. Our EFT terms and conditions neither enlarge nor diminish the parties' respective rights and obligations within any applicable agreement. The payment due date is not affected. We will consider payment made when your financial institution has received or has control of the payment transaction. This will generally occur within three (3) calendar days following initiation by PGBA. If payment is initiated on a nonbanking day at PGBA's originating bank, the funds transfer will occur the following banking day. In all cases, "Banking Day" is defined as the day on which both trading partners' banks are available to transmit and receive these fund transfers.
5. With respect to the EFT reimbursement process, PGBA is responsible up to the point where your financial institution receives or has control of the transaction. Any loss of data at that point will be borne by you unless the loss is due solely to the negligence of PGBA or its originating bank.

You hereby represent that you are authorized to enter into this agreement, disburse funds, sign checks, and modify account information for the provider locations listed below.

NAME: _____ SIGNATURE: _____
(Print)
TITLE: _____ DATE: _____



TRICARE ERA/EFT ENROLLMENT FORM

Transaction Type:

EFT (Electronic Funds Transfer)

ERA (Electronic Remittance Advice)

General Provider Information		
Provider's Name		
Address		
City	State	ZIP
Phone	E-mail Address	
Federal Tax ID	NPI	

Electronic Remittance Advice (ERA) Information
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I hereby authorize _____ to receive
Billing Service/Clearinghouse/Trading Partner

Electronic Remittance Advices (ERA's) on my behalf. I understand that ERA's contain payment information concerning my processed TRICARE claims. I acknowledge that it is my responsibility to notify PGBA, LLC in writing if I wish to revoke this authorization.

EDIG Trading Partner ID/Submitter ID	
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Electronic Funds Transfer (EFT) Information		
Bank Name		
Address		
City	State	ZIP
Bank Contact Name	Phone	
Bank Transit/Routing Number	Account Number	
Type of Account	Saving	Checking

I hereby authorize PGBA, LLC to initiate credit entries and, if necessary, debit entries and adjust and credit entries in error. I also authorize the bank named above to credit and/or debit the same to this account.

Signature(s)	
Name/Title (<i>Please Print</i>)	Date
Signature (<i>I am authorized to endorse this enrollment on behalf of my company.</i>)	Phone

This authorization is to remain in full force and effect until PGBA, LLC has received faxed notification of its termination.

