



**NON-NETWORK TRICARE INSTITUTIONAL PROVIDER APPLICATION**

FACILITY NAME: \_\_\_\_\_ FEDERAL TAX NUMBER: \_\_\_\_\_

NPI# \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

OFFICE LOCATION (Street Address): \_\_\_\_\_ MAILING ADDRESS (If different): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the facility Medicare certified: \_\_\_\_\_ YES \_\_\_\_\_ NO If yes:

Original Certification No.: \_\_\_\_\_ Original Certification Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the facility JCAHO certified: \_\_\_\_\_ YES \_\_\_\_\_ NO Original Certification Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**YOU MUST ATTACH COPIES OF MEDICARE, JCAHO AND STATE LICENSING.**

What is your facility classified as? ( check the most appropriate classification)

- |   |   |
|---|---|
| <input type="checkbox"/> Ambulatory Surgery Center      | <input type="checkbox"/> Swing Bed Unit             |
| <input type="checkbox"/> Children's Hospital            | <input type="checkbox"/> Psych Unit                 |
| <input type="checkbox"/> Chronic Disease Institute      | <input type="checkbox"/> Psychiatric Hospital       |
| <input type="checkbox"/> College Infirmary              | <input type="checkbox"/> Long Term General Hospital |
| <input type="checkbox"/> Extended Care Facility         | <input type="checkbox"/> Rehab Unit                 |
| <input type="checkbox"/> Short Term Acute Care Hospital | <input type="checkbox"/> Sole Community Hospital    |
| <input type="checkbox"/> Other: _____                   |   |

If your facility is a new psychiatric hospital, a skilled nursing facility (SNF) or a birthing center, you must complete additional forms. Please contact TRICARE Services or visit myTRICARE.com to obtain these additional forms.

Residential Treatment Facilities (RTC), Partial Hospitalization Program (PHP) and Substance Use Disorder Rehabilitation Facilities (SUDRF) must be certified by:

NQMC – MAXIMUS, Inc.  
1600 E. Northern Avenue  
Suite 100  
Phoenix, AZ 85020  
Telephone: 1-602-308-7178

PGBA, LLC  
Provider Data Management  
P.O. Box 870156  
Surfside Beach, SC 29587-9756  
1-877-TRICARE (1-877-874-2273)  
Fax 1-888-279-3540  
www.myTRICARE.com by PGBA



**Non-Network UB-04 “Signature on File” for TRICARE Claims Form**

Please complete the following information and return by fax to 1-888-250-4355

This form serves the purpose of the signature requirements indicated in the TRICARE Operations Manual (Chapter 8, Section 4, Paragraph 10.0.)

“The signature of the non-network provider, or an acceptable facsimile, is required on all participating claims. The provider’s signature block Form Locator (FL) has been eliminated from the CMS 1450 UB-04. As a work around, the National Uniform Billing Committee (NUBC) has designated FL 80, Remarks, as the location for the signature, if signature on file requirements do not apply to the claim. If a non-network participating claim does not contain an acceptable signature, return the claim.”

I, \_\_\_\_\_ hereby authorize PGBA, LLC / Health Net  
(print/type name here)

Federal Services in the state of South Carolina to accept my signature shown below as my true signature for all claim submissions for the facility indicated below.

Facility Name: \_\_\_\_\_

Facility Tax Identification Number: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Facility Phone Number: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

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**ELECTRONIC FUNDS TRANSFER (EFT)**

Complete and FAX/Mail to: TRICARE North EFT, PO Box 870154, Surfside Beach, SC 29587-9754 or FAX completed form to 1-888-536-2324. (For assistance contact our EDI Help desk at, 1-877-334-2524).

**PART I – PROVIDER OR SUPPLIER INFORMATION**

Tax Identification ( EIN or  SSN) \_\_\_\_\_  
National Provider Identifier \_\_\_\_\_  
Name \_\_\_\_\_  
Business Physical Address \_\_\_\_\_  
\_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**PART II – BANKING INFORMATION**

Bank name \_\_\_\_\_  
Bank Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Bank contact name: \_\_\_\_\_ Phone Number \_\_\_\_\_  
Bank Transit Number/ Routing Number (nine digit) \_\_\_\_\_ Bank  
Account Number \_\_\_\_\_  
Type of Account (check one)  Checking Account  Saving Account

**PART III – CONTACT PERSON**

Name \_\_\_\_\_  
Business Physical Address \_\_\_\_\_  
\_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_  
E-mail Address \_\_\_\_\_

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 (person with signature authority) \_\_\_\_\_ Date \_\_\_\_\_

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