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: ____/_____/____

<u>YOU MUST ATTACH COPIES OF MEDICARE, JCAHO AND STATE LICENSING.</u>

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

____ Ambulatory Surgery Center
____ Children's Hospital
____ Chronic Disease Institute
____ College Infirmary
____ Extended Care Facility
____ Short Term Acute Care Hospital
____ Swing Bed Unit
____ Psych Unit
____ Psychiatric Hospital
____ Long Term General Hospital
____ Rehab Unit
____Sole Community Hospital
____ 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:

KePRO
Attn: TRICARE Operations
777 East Park Drive
Harrisburg, PA 17111

Fax: 877.841.6414
E-mail: tricare@kepro.com
Phone: 877.841.6413

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: ____

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

ELECTRONIC FUNDS TRANSFER (EFT)

Compete 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
____City
______________________________ State _________ Zip Code ______________

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
____City
______________________________ State _________ Zip Code ______________

Phone Number ______________________ Fax Number ______________________
E-mail Address ____

I hearby 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

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