TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039
Fax: 803-462-3992

Toll-Free: 1-800-403-3950

TRICARE 'LIMITED' PROVIDER FILE APPLICATION

NAME: ____ SOCIAL SECURITY NUMBER: _______________________

NPI#____

IF YOU ARE SOLO INCORPORATED, PLEASE GIVE EIN NUMBER: _______________________________________

Office Location (Street Address):

____

____

Payment Address (If different):

____

____

Office Telephone No: (_____) ______-_________

Payment Telephone No: (_____) ______-________

If you file your taxes under a Federal Employer Identification Number because you belong to an incorporated group/professional association, you must also complete a GROUP APPLICATION and the enclosed REASSIGNMENT OF BENEFIT FORM.

Are you a member of an established group practice or institution? _______ YES _______ NO

If YES, Practice Name: ____ Provider Number: ________________________

Date you began employment with group number: ________/________/________

Do you maintain a solo practice? _______ YES _______ NO

I will be signing my own claim forms: _______ YES _______ NO
If NO, then the enclosed Facsimile Signature Authorization Form(s) must be completed.

I certify that all applicable licensing and other regulatory requirements that are extant in that state, county, municipality, or other political jurisdiction in which the ECHO service is rendered to be reimbursed as a(n):

____.

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ATTACH A PHOTOCOPY OF YOUR LICENSE OR CERTIFICATION

Are you currently certified by BACB (Behavioral Analyst Certification Board):

Yes _____ No ____

BACB Certification No: _______________________

Are you currently State certified or licensed:

Yes ___ No____

CONFLICT OF INTEREST STATEMENT

"Federal Law (5 U.S.C. 5536) prohibits medical personnel who are active duty members or civilian employees of the 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 spouse/beneficiary. Claims for TRICARE benefits will be denied whether 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 ECHO program, do affirm and attest that the information which I have provided in response to support of this application is true and correct. I understand that any misrepresentation of my credentials which bear upon my qualification for authorized TRICARE ECHO provider status may be subject to the administrative Remedies for Fraud, Abuse and Conflict of Interest as defined in Chapter 9 of the TRICARE Regulation, DoD 6010.8-R and/or 32 CFR 199.9.

____ ___________________________

Signature of Applicant **Signature Date**

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

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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 Contractor for the TRICARE in the state of ____________________________________ to accept my facsimile or stamp signature shown below as my true signature, including my agreeing to abide by the TRICARE payment system 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**

SUBSRIBED AND SWORN TO BEFORE ME THIS __________ DAY OF _____________, 20____.

____
NOTARY PUBLIC IN AND FOR

COUNTY OF ________________________________ STATE OF ____

(SEAL) MY COMMISION EXPIRES _______/_______/_______

Per TRICARE Management Activity (TMA) guidelines, we may accept in lieu of a provider's actual signature on a TRICARE claim form, a facsimile signature. The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim 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)

____
(Address)

____

____

________________________________ ________________________________
Authorized Signature for Clinic | Signature of Provider

________________________________ ______________________/__________________
Employer Identification Number | Social Security Number / NPI#

________________________________ ________________________________
Date | Date

Date Individual joined group practice ____

Please return to the address listed below.

PLEASE RETURN FORMS TO:
PGBA, LLC
TRICARE Extended Care Health Option
PO Box 7036
Camden SC 29020-7036

TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039
Fax: 803-462-3992

Toll-Free: 1-800-403-3950

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

GROUP NAME: ____

FEDERAL TAX NUMBER: ______________________________NPI#___________________________________

Office Tele. No: (______) _________-___________ **Billing Tele. No:** (______) _________-___________

Office Location (Street Address): **Mailing Address (If different):**

____ ____

____ ____

Date legal entity established _______/_______/________

Are group members all the same specialty? ________**YES** ________ **NO**

If YES, name the specialty: ____

Will each provider sign his or her own claim form? ________**YES** ________ **NO**

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

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GROUP MEMBER LISTING

Please list all of the rendering providers associated with your group.

PLEASE COMPLETE ALL FIELDS AND RETURN WITH COVER LETTER AND APPLICATION.

NAME Last, First, MI	SSN AND NPI NUMBERS	CERTF/LICENSE NUMBER	PRIMARY SPECIALTY	DATE JOINED GROUP

HUMANA MILITARY
HEALTHCARE SERVICES
★ ★ ★ ★ ★
A Legacy of Service