



**TRICARE Non-Network Individual Application**  
**Registered Nurse (RN)/Licensed Practical Nurse (LPN)/Nurse Practitioner (NP)/Midwife**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Gen: \_\_\_\_\_ Title: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ NPI# \_\_\_\_\_

Physical Address (Street Address): \_\_\_\_\_ Billing Address (If Different): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Telephone No: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

\*\* Please attach a list of additional office locations.

Do you maintain a solo practice? \_\_\_Yes \_\_\_No

If yes, Tax ID # of solo practice: \_\_\_\_\_

NPI# \_\_\_\_\_

Date you began using this Tax ID #: \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you work with an established group practice or institution? \_\_\_Yes \_\_\_No

If yes, practice name: \_\_\_\_\_

Practice Tax ID #: \_\_\_\_\_

NPI# \_\_\_\_\_

Date you began practicing with this group number: \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you sign your own claim forms? \_\_\_ Yes \_\_\_ No

If no, Signature Authorization forms are attached. Please complete these forms and have them notarized.



RN/LPN

In order to become TRICARE-certified as a RN or LPN, you must be licensed as such. Please attach a copy of your RN license or your LPN license.

RN or LPN License information:

RN or LPN License Number: \_\_\_\_\_

Original Issue Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Attach a copy of your state license.

Nurse Midwife

In order to become TRICARE-certified as a Nurse Midwife, you must be licensed as a RN in addition to certification by the American College of Nurse Midwives.

RN Midwife license and certification information:

License Number: \_\_\_\_\_ Certification Number: \_\_\_\_\_

Original Issue Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Attach a copy of your state license.

Nurse Practitioner

In order to become TRICARE-certified as a NP, you must also be licensed as a RN.

NP License Information:

License Number: \_\_\_\_\_ Certification Number: \_\_\_\_\_

Original Issue Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Attach a copy of your state license. If a state does not offer a NP license, attach RN license and copy of National Certification.



**PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION**

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

\_\_\_\_\_ being first duly sworn, deposes and says: I hereby authorize PGBA, LLC / Health Net Federal Services in the state of South Carolina to accept my facsimile or stamp signature shown below

(Facsimile, stamp or computer-generated signature as it will appear on the claim form)

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 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

SUBSCRIBED AND SWORN TO BEFORE ME THIS \_\_\_ DAY OF \_\_\_ 20 \_\_\_

\_\_\_\_\_  
NOTARY PUBLIC IN AND FOR

COUNTY OF \_\_\_\_\_ STATE OF \_\_\_\_\_

(SEAL)

MY COMMISSION EXPIRES: \_\_\_\_\_



**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 \_\_\_\_\_ 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 \_\_\_\_\_



**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 \_\_\_\_\_  
\_\_\_\_\_ 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 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 \_\_\_\_\_