



Non-Network Dentist/Physician Individual Application

First Name: _____ MI: _____ Last Name: _____

Gen: _____ Title: _____

Social Security Number: _____

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

Tax ID # of solo practice: _____

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 #: _____

Date you began practicing with this group number: ____/____/____

PGBA, LLC
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756
1-877-TRICARE (1-877-874-2273)
Fax: 1-888-250-4355
www.myTRICARE.com by PGBA



License Number: _____

Original License Date: ____/____/____ Current Expiration Date: ____/____/____

Please attach a copy of your current state license.

Specialty: _____ UPIN: _____

Are you:

Employed by the US Government _____ Yes _____ No

Resident _____ Yes _____ No

Signing own claim forms _____ Yes _____ No

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

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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 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: _____

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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 _____ 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 _____