



TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039
Fax 803-462-3986

Toll-Free: 1-800-403-3950

TRICARE
BIRTHING CENTER
PROVIDER APPLICATION

Please submit the completed application package to:

Fax:
803-462-3986

or

Mail to:
TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039



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TRICARE
 INSTITUTIONAL PROVIDER APPLICATION

FACILITY NAME: _____

FEDERAL TAX NO: _____ NPI #: _____

Office Tele. No: (____) ____ - ____ ext. _____ Billing Tele. No: (____) ____ - ____ ext. _____

OFFICE LOCATION (Street Address): _____ MAILING ADDRESS (If different): _____

Is the facility Medicare certified: YES NO If yes:

CERTIFICATION NO. (ORIGINAL): _____ CATEGORY: _____

ORIGINAL CERT. DATE: __/__/____ CURRENT CERT. DATES: __/__/____ TO __/__/____

Is the facility JCAHO certified: YES NO If yes:

JCAHO CLASSIFICATION: _____

ORIGINAL CLASS. DATE: __/__/____ CURRENT CLASS. DATES: __/__/____ TO __/__/____

STATE LICENSE CLASSIFICATION (ORIGINAL): _____

ORIGINAL LICENSE DATE: __/__/____ CURRENT LICENSE DATES: __/__/____ TO __/__/____

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

Is your facility classified as a:

- Sole Community Hospital (attach proof of Medicare Classification)
- Children's Hospital
- Teaching Facility Please complete the following:

Number of Beds, excluding exempt unit _____
 Number of Intern/Residents at most recent Fiscal Year end _____

Residential Treatment Facilities (RTC), Substance Use Disorder Rehabilitation Facilities (SUDRF) and Freestanding Psychiatric Partial Hospitalization Programs (PHP) must be certified by the TRICARE Quality Monitoring Contract (TQMC - KePro).

TQMC - KePro
 777 East Park Drive
 Harrisburg PA 17111
 Phone: 877-841-6413
 E-mail: tricare@kepro.com





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HEALTH PROGRAM BENEFIT AGREEMENT

In order to receive payment under TRICARE Management Activity (TMA),

_____ dba

_____ as the provider of services agrees:

- A. To accept as payment for inpatient services provided to eligible beneficiaries, the TRICARE-determined allowable amount will be determined in accordance with the requirements of 32 CFR 199.
- B. To refrain from billing the TRICARE-eligible beneficiary for amounts which exceed the TRICARE-determined allowable amount except for services not covered by TRICARE as described in 32 CFR 199 and for amounts which constitute the TRICARE beneficiary's liability for cost-share and deductible.

TMA agrees:

(A) to pay the hospital the full allowable amount less any applicable cost-share and deductible amounts.

This agreement shall be binding on the provider and TMA upon submission by the provider of acceptable assurance of compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Director, TMA, or a designee.

This agreement shall be effective until terminated by either party. The effective date shall be the date the agreement is signed by TMA.

The agreement may be terminated by either party by giving the other party written notice of termination. Such notice of termination is to be received by the other party no later than 30 days prior to the date of termination. In the event of transfer of ownership, this agreement is assigned to the new owner, subject to the conditions specified in this agreement and pertinent regulations.

FOR PROVIDER OF SERVICES BY:

FOR TMA BY:

NAME

NAME

TITLE

TITLE

DATE

DATE





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An Assistant Surgeon is a physician, dentist or podiatrist acting within the scope of their license who actively assists the operating surgeon in the performance of a covered surgical service. Physician assistants are also recognized as assistant surgeons under TRICARE. TRICARE benefits are allowable only when the assistant surgeon is considered **MEDICALLY NECESSARY**. Services of an assistant surgeon are considered medically necessary when the surgical procedure is of the complexity and seriousness as to warrant a surgical assistant (other than the surgical nurse or other such operating room personnel) and interns, residents or other hospital staff are **NOT** available to provide surgical assistance.

The operating surgeon must certify in writing to the nonavailability of a qualified intern, resident or other hospital physician. In lieu of the operating surgeon's certification, the hospital may certify that they do not have internal staff available at any time to perform the services of assistant surgeons.

If the statement below pertains to your facility, we will document our files accordingly. Please return this form with the signature of an authorized hospital representative with the enclosed application package.

I, _____, CERTIFY THAT THE FACILITY NOTED BELOW HAS NO INTERNAL STAFF AVAILABLE AT ANY TIME TO PERFORM THE SERVICES OF ASSISTANT SURGEON.

SIGNATURE TITLE DATE

NAME OF FACILITY: _____



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UB-04 "Signature on File Form" For TRICARE Claims

Beginning January 1, 2008, all UB-04 paper claims submissions for TRICARE must include a signature on the claim form in order to process. The provider signature should be applied in the "Remarks Field (FL80) of the UB-04 claim form.

However, if you would like to eliminate the need to apply a signature in the remarks field on each and every claim submitted please complete this form and return it to the fax number provided.

In order to prevent delays in processing your TRICARE claims we are offering this "Signature on File Form."

Please provide the information requested below and fax this form to the PGBA fax number listed. Once received at PGBC, this completed form will be retained and applied for future claims submissions from your facility thus eliminating the need to apply a signature to each individual claim filed.

Facility Name: _____

Facility Tax Identification Number: _____

Signature of Authorized Representative: _____

Signature on this form certifies that any changes submitted by the facility on a UB-04 are true, accurate and correct. Signature on this form meets the policy requirement from TRICARE Operations Chapter 8, Section 10, as stated below and negates the need for a signature in block 80 of the UB-04.

"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 8/0, Remarks, as the location for the signature, if signature on file requirements does not apply to the claim. If a non-network participating claim does not contain an acceptable signature, return the claim."



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TRICARE
 BIRTHING CENTER QUESTIONNAIRE

DATE: _____

NEW APPLICATION
 CHANGE OF FILE INFORMATION

1. FACILITY NAME: _____

2. FEDERAL TAX ID NUMBER: _____

3. FACILITY LOCATION (Street Address):	MAILING ADDRESS (If different):
_____	_____
_____	_____
_____	_____
_____	_____

4. NAME AND TITLE OF CHIEF OPERATING OFFICER (COO):

TELEPHONE: (____) ____ - ____ ext.____ EMERGENCY: (____) ____ - ____ ext.____

5. NAME OF LIAISON FOR TRICARE INQUIRIES:

6. TYPE OF LEGAL ORGANIZATION FOR THE FACILITY:

7. NAME AND BUSINESS ADDRESS OF EACH MEMBER OF THE CENTER'S GOVERNING BODY: (Attach additional pages if necessary)





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8. Is the facility accredited by at least ONE of the following organizations?
- | | | |
|-----|----|---|
| YES | NO | JCAHO (Joint Commission on Accreditation of Healthcare Organizations) |
| YES | NO | AAAH (Accreditation Association for Ambulatory Health Care, Inc.) |
| YES | NO | The Commission for the Accreditation of Freestanding Birth Centers |
9. Please submit legible photocopies of the most recent accreditations (Mentioned above)
REQUIRED
10. Please submit a legible photocopy of the most recent written Memorandum of Understanding (MOU) for routine consultation and emergency care with an obstetrician-gynecologist who is certified or is eligible for certification by the American Board of Obstetrics and Gynecology, who has admitting privileges to at least one backup hospital. In lieu of a required MOU, the center may employ a physician with the required qualifications. Each MOU must be renewed annually
REQUIRED
11. Please submit a legible photocopy of the most recent written Memorandum of Understanding (MOU) for routine consultation and emergency care with a pediatrician who is certified or eligible for certification by the American Board of Pediatrics or by the American Osteopathic Board of Pediatrics, who has admitting privileges to at least one backup hospital. In lieu of a required MOU, the center may employ a physician with the required qualifications. Each MOU must be renewed annually. **REQUIRED**
12. Please submit a legible photocopy of the most recent written Memorandum of Understanding (MOU) with at least one backup hospital which documents that the hospital will accept and treat any woman or newborn transferred from the center who is in need of emergency obstetrical or neonatal medical care. In lieu of this MOU with a hospital, a birthing center may have an MOU with a physician, who otherwise meets the requirements as a TRICARE individual professional provider, and who has admitting privileges to a backup hospital capable of providing care for critical maternal and neonatal patients as demonstrated by a letter from the hospital qualifying the scope and expected duration of the admitting privileges granted by the hospital to the physician. The MOU must be renewed annually. **REQUIRED**
13. Please submit a legible photocopy of the most recent written Memorandum of Understanding (MOU) with at least one ambulance service which comments that the ambulance service is routinely staffed by qualified personnel who are capable of the management of critical maternal and neonatal patients during transport and which specifies the estimated transport time to each backup hospital in which the center has arranged for emergency treatment as required in paragraph above. Each MOU must be renewed annually. **REQUIRED**



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I have completed this application to the best of my ability and knowledge and certify it is true and correct. Furthermore, I understand that the Birthing Center shall not be a TRICARE authorized institutional provider and TRICARE benefits shall not be paid for any service provided by the Birthing Center before the date the participation agreement is signed by the Director, TRICARE Management Activity (TMA), or a designee.

(Signature of Chief Executive Officer)

(Date)

(Printed Name)

(Title)

Please return to the address indicated above.

NOTE: An incomplete application may result in the denial of TRICARE authorization for the facility.

For additional assistance, please contact us at our toll-free customer service number, write to our Provider Data Management Department address or visit us at the PGBA, LLC Web address.



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PARTICIPATION AGREEMENT FOR
FREESTANDING OR INSTITUTION-AFFILIATED
BIRTHING CENTER
MATERNITY CARE SERVICES FOR TRICARE BENEFICIARIES

FACILITY

ADDRESS

ADDRESS

(____) ____ - ____ ext. _____
TELEPHONE

TRICARE ASSIGNED BILLING NUMBER

TRICARE Management Activity (TMA)
United States Department of Defense
Aurora, Colorado 80045-6900



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ARTICLE 1 RECITALS

1.1 Identification of Parties

This Participation Agreement is between the United States of America through the Department of Defense, TRICARE Management Activity (hereinafter TMA), a field activity of the Office of the Secretary of Defense, the administering activity for the TRICARE and

_____ doing
business as _____
(hereinafter designated birthing center or BC).

1.2 Authority for Birthing Center (BC) Care

The implementing regulations for the TRICARE, 32 Code of Federal Regulations Part 199, provides that the TRICARE may share the cost of maternity care usual for a low-risk pregnancy and uncomplicated birth provided by a BC under certain conditions.

1.3 Intent of Agreement

It is the intent of this participation agreement to recognize the undersigned BC as a TRICARE-authorized provider of certain maternity care services, subject to terms and conditions of this agreement.

ARTICLE 2 DEFINITIONS

2.1 Admission

The formal acceptance by a TRICARE-authorized institutional provider of a TRICARE beneficiary for the purpose of diagnosis and treatment of illness, injury, pregnancy, or mental disorder.

2.2 Authorized TMA Representatives

The authorized representative(s) of the Director, TMA, may include, but are not limited to, TMA staff, Department of Defense personnel, Health and Human Services audit staff and TMA contractors, including contractor consultants, such as private sector accounting/audit firm(s).

2.3 Back-Up Hospital(s)

A hospital which is otherwise eligible as a TRICARE institutional provider and which is fully capable of providing emergency care to a patient who develops complications beyond the scope of services of a given category of TRICARE-authorized freestanding institutional provider and which is accessible from the site of the TRICARE-authorized freestanding institutional provider within an average transport time acceptable for the types of medical emergencies usually associated with the type of care provided by the freestanding facility.



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2.4 Billing Number

The unique number assigned to a specific birthing center by the contractor which is used by the birthing center to identify all claims for reimbursement from the TRICARE.

2.5 Birthing Center

A birthing center is a free-standing or institution-affiliated outpatient maternity care program which principally provides a planned course of outpatient prenatal care and outpatient childbirth service limited to low risk pregnancies; excludes care for high-risk pregnancies; limits childbirth to the use of natural childbirth procedures; and provides immediate newborn care.

2.6 Birthing Room

A room and environment designed and equipped to provide care, to accommodate support persons, and within which a woman with a low-risk, normal, full-term pregnancy can labor, deliver, and recover with her infant.

2.7 Discharge

A discharge occurs at the time that the BC formally releases the beneficiary-patient from patient status; or when the beneficiary-patient is admitted to an acute medical hospital upon transfer from the BC.

2.8 Free-standing

Not "institution-affiliated" or "institution-based."

2.9 High-Risk Pregnancy

A pregnancy is high-risk when the presence of a currently active or previously treated medical, anatomical, or physiological illness or condition may create or increase the likelihood of a detrimental effect on the mother, fetus, or newborn and presents a reasonable possibility of the development of complications during labor or delivery.

2.10 Institution-affiliated

Related to a TRICARE-authorized institutional provider through a shared governing body but operating under a separate and distinct license or accreditation.

2.11 Institution-based

Related to a TRICARE-authorized institutional provider through a shared governing body and operating under a common license and shared accreditation.

2.12 Jurisdictional FI

The TRICARE fiscal intermediary responsible for the geographic area in which the birthing center is located.



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2.13 Low-risk Pregnancy

A pregnancy is low-risk when the basis for the ongoing clinical expectation of a normal uncomplicated birth, as defined by reasonable and generally accepted criteria of maternal and fetal health, is documented throughout a generally accepted course of prenatal care.

2.14 Most-favored Rate

The lowest usual charge to any individual or third-party payer in effect on the date of the admission of a TRICARE beneficiary.

2.15 Natural Childbirth

Childbirth without the use of chemical induction or augmentation of labor or surgical procedure other than episiotomy or perineal repair.

ARTICLE 3 PERFORMANCE PROVISIONS

3.1 General Agreement

- (a) The BC agrees to render maternity care services to eligible TRICARE beneficiaries in need of such services, in accordance with this participation agreement and the TRICARE regulation; and,
- (b) Participate in TRICARE and accept payment for maternity services based upon the reimbursement methodology for birthing centers; and,
- (c) Notify the Operations Directorate (DO), TMA, 16401 East Centretch Parkway, Aurora, CO 80011-9043, in writing, within seven (7) calendar days of the emergency transport of any TRICARE beneficiary from the center to an acute care hospital or of the death of any TRICARE beneficiary in the center.

3.2 Billings

Billings by the BC are subject to all regulatory limits, including but not limited to the requirements that the care be medically necessary.

3.3 Accreditation and Standards

The BC hereby certifies that:

- (a) It is accredited by a nationally recognized accreditation organization whose standards and procedures have been determined to be acceptable by the Director, TMA, or a designee; and,
- (b) It is in compliance with TRICARE Birthing Center Standards; and,
- (c) It is licensed as a birthing center where such license is available, or is specifically licensed as a type of ambulatory health care facility where birthing center specific license is not available; and,
- (d) It meets all applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the center is located.



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3.4 Appointment of Liaisons

The BC shall designate an individual who will act as liaison for TRICARE inquiries. The TRICARE jurisdictional FI shall be informed in writing of the designated individual.

3.5 Quality of Care

Under the terms of this agreement, the BC shall:

- (a) Assure that each eligible TRICARE beneficiary receives care which complies with the underlying standards and requirements in Article 3.3; and,
- (b) Provide services in the same manner to TRICARE beneficiaries as it provides to all patients to whom it renders services; and,
- (c) Not discriminate against TRICARE beneficiaries in any manner, including admission practices, placement in special or separate wings or rooms, or provisions of special or limited treatment.

ARTICLE 4 PAYMENT PROVISIONS

4.1 Rate Structure

- (a) Reimbursement for maternity care furnished by an authorized birthing center shall be limited to the lower of the TRICARE established all-inclusive rate or the center's most-favored all-inclusive rate.
- (b) The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: laboratory studies, prenatal management, labor management, delivery, post-partum management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility.
- (c) The TRICARE established all-inclusive rate is equal to the sum of the TRICARE area prevailing professional charge for total obstetrical care for a normal pregnancy and delivery and the sum of the average TRICARE allowable institutional charges for supplies, laboratory, and delivery room for a hospital inpatient normal delivery.
- (d) Extraordinary maternity care services, when otherwise authorized, may be reimbursed at the lesser of the billed charge or the TRICARE allowable charge.
- (e) Reimbursement for an incomplete course of care will be limited to claims for professional services and tests where the beneficiary has been screened but rejected for admission into the birthing center program, or where the beneficiary has been admitted but is discharged from the birthing center program prior to delivery. These charges will be adjudicated by TRICARE as individual professional services and items.
- (f) The beneficiary's share of the total reimbursement to a birthing center is limited to the costshare amount plus the amount billed for non-covered services and supplies.



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4.2 TRICARE Determined Rate as Payment in Full

- (a) The BC agrees to accept the TRICARE allowed amount determined pursuant to Article 4.1, above, as the total charge for all-inclusive care for a normal pregnancy and uncomplicated childbirth and for any TRICARE approved extraordinary services or items. The BC agrees to accept the TRICARE rate even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE, combined with the cost-share amount and deductible, if any, paid by or on behalf of the beneficiary-patient, as full payment for the rendered services and supplies. The BC agrees to make no attempt to collect from the beneficiary-patient, as full payment for the rendered services and supplies. The BC agrees to make no attempt to collect from the beneficiary-patient (or sponsor), except as provided in Article 4.4 (a), amounts for services and supplies in excess of the TRICARE allowed amount.
- (b) TMA agrees to make any benefits payable directly to the BC.

4.3 TRICARE as Secondary Payor

- (a) The BC shall comply with the TRICARE provisions for double coverage set forth in 32 CFR 199.8. The BC shall submit claims first to all other insurance plans and/or medical service or health plans under which the beneficiary has coverage prior to submitting a claim to TRICARE.
- (b) Failure to collect first from primary health insurers and/or sponsoring agencies may result in denial or reduction of payment. It may also result in termination by TMA of this agreement pursuant to Article 7.

4.4 Collection of Cost Share

- (a) The BC agrees to collect from the TRICARE beneficiary or the parents or guardian of the TRICARE beneficiary only those amounts applicable to the beneficiary cost-share as defined in 32 CFR 199.4 and services and supplies which are not a benefit of TRICARE.
- (b) Failure of the BC to collect or to make diligent effort to collect the beneficiary's costshare as determined by TRICARE policy is a violation of this agreement, which may result in denial or reduction of payment, and, if willful, may be considered a false claim against the United States government. It may also result in termination by TMA of this agreement pursuant to Article 7.

4.5 Beneficiary Rights

If the BC fails to abide by the terms of this participation agreement and TMA or its designee either denies the claim or claims and/or terminates the agreement, as a result of the BC's breach, the BC agrees to forego its rights, if any, to pursue the amounts not paid by TRICARE from the beneficiary or the beneficiary's family.



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ARTICLE 5 RECORDS AND AUDIT PROVISIONS

5.1 On-Site and Off-Site Reviews and Audits

The BC grants the Director, TMA {or authorized representative(s)}, the right to conduct quality assurance audits or accounting (record) audits with full access to patients and records. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit and/or review includes, but is not limited to:

- (a) Examine fiscal and all other records of the BC which would confirm compliance with this agreement and designation as an authorized TRICARE BC provider.
- (b) Conduct such audits of BC records including clinical, financial, and census records, as may be necessary to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided TRICARE beneficiaries.
- (c) Examine reports of evaluations and inspections conducted by federal, state, local government, and private agencies and organizations.
- (d) Conduct on-site inspections of the facilities of the BC and to interview employees, members of the staff, contractors, board members, volunteers, and patients, as may be required.

5.2 Audited Cost Reports

Upon request, the BC shall furnish TMA (and authorized designees) audited cost reports certified by an independent auditing agency.

5.3 Records

The BC shall furnish TMA, when requested, such records, including medical records and patient census records, that would allow TMA to determine the quality and cost-effectiveness of care rendered.

5.4 Failure to Provide Records

Failure to allow audits/reviews and/or to provide records constitutes a material breach of this agreement.

ARTICLE 6 NONDISCRIMINATION

6.1 Compliance

The BC agrees to comply with provisions of section 504 of the Rehabilitation Act of 1973 (Public Law 93-112; as amended) regarding nondiscrimination on the basis of handicap and Title VI of the Civil Rights Act of 1964 (Public Law 88-352).



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ARTICLE 7 TERMINATION AND AMENDMENT

7.1 Termination of Agreement by TMA

The Director, TMA, or a designee, may terminate this agreement:

- (a) Upon 30 days written notice, for cause, if:
 - (1) The BC is not complying substantially with the provisions of this agreement or with requirements set forth in the Dependents Medical Care Act, as amended (10 USC 1071-1093), or its implementing regulations; or
 - (2) The BC no longer meets the conditions of participation as established under the Act, its implementing regulations, or the TRICARE standards for birthing centers.
- (b) Upon 48 hours notice, either written or oral:
 - (1) In the event that the BC's failure to comply with the TRICARE standards for birthing centers presents an immediate danger to life, health or safety.
 - (2) Based on a determination of provider fraud or abuse, as established by TRICARE regulation.

7.2 Termination of Agreement by the BC

The BC may terminate this agreement by giving the Director, TMA, or designee, written notice of such intent to terminate at least 60 calendar days in advance of the effective date of termination.

7.3 Amendment by TMA

- (a) The Director, TMA, or designee, may amend the terms of this participation agreement by giving 120 days notice in writing of the proposed amendment(s).
- (b) The BC may, if it concludes it does not wish to accept proposed amendment(s), terminate its participation as provided for in Article 7.2.

7.4 Claims Processing and Recoupment

The notice provisions in this article do not limit TMA'S authority to suspend claims processing or seek recoupment of claims previously.



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ARTICLE 8 TRANSFER OF OWNERSHIP

8.1 Assignment Barred

This agreement is nonassignable.

8.2 New Agreement Required

- (a) If there is a change of ownership of a BC as specified in Article 8.2 (b), then the new owner, in order to be a TRICARE authorized birthing center, must enter into a new agreement with TMA except as provided in Article 8.2 (c). The new owner is subject to any existing plan of correction, expiration date, applicable health and safety standards, ownership and financial interest disclosure requirements and any other provisions and requirements of this agreement.
- (b) Change of Ownership
 - (1) The change in owner(s) that has (have) 50 percent or more ownership constitutes change in ownership.
 - (2) The merger of the BC corporation (profit or nonprofit) into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation, constitutes change in ownership. However, transfer of corporate stock or the merger of another corporation into the BC corporation does not constitute change of ownership.
The transfer of title to property of the BC corporation to another corporation(s), and the use of that property for the rendering of birthing center care by the corporation(s) receiving it is essential for a change of ownership.
 - (3) The lease of all or part of a BC or a change in the BC's lessee constitutes change in ownership.
- (c) A birthing center contemplating or negotiating a change in ownership must notify TMA in writing at least thirty (30) days prior to the effective date of the change. At the discretion of the Director, TMA, or the Director's designee, this agreement may remain in effect until a new participation agreement can be signed to provide continuity of coverage for beneficiaries.

ARTICLE 9 GENERAL ACCOUNTING OFFICE

9.1 Right to Conduct Audit

The BC grants the United States General Accounting Office the right to conduct audits.



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ARTICLE 10
 APPEALS

10.1 Appeal Actions

Appeals of TMA actions under this agreement, to the extent they are allowable, will be pursuant to 32 CFR 199.10.

ARTICLE 11
 EFFECTIVE DATE

11.1 Date Signed

This participation agreement will be effective on the date signed by the Director, TMA, or a designee.

ARTICLE 12
 AUTHORIZED PROVIDER

12.1 Date Recognized

On the effective date of the agreement, TMA recognizes the BC as an authorized provider for purposes of providing birthing center services to TRICARE eligible beneficiaries.

_____ Birthing Center

By: _____
 Signature

_____ Typed Name

_____ Typed Title

Executed on _____, 20 ____

_____ TMA

By: _____
 Signature

_____ Typed Name

_____ Typed Title

Executed on _____, 20 ____





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TERMS AND CONDITIONS FOR ELECTRONIC FUNDS TRANSFER

By Signing below your company agrees to accept payment by PGBA, LLC (PGBA) through electronic funds transfer (EFT). Additionally, you acknowledge and agree that all payments shall be made in accordance with the information that you supply on the Electronic Funds Transfer Authorization Form and that PGBA shall be entitled to rely exclusively upon such information. This agreement applies to and amends all existing agreements with PGBA by incorporating the following terms and conditions for electronic payment. PGBA will initiate payment to you based on the following:

1. PGBA will transfer funds electronically to the financial institution and account number you register on the attached EFT/ERA Enrollment Form.
2. PGBA will make payments in accordance with and be governed by the National Automated Clearinghouse Association’s Corporation Trade Payment Rules. Our process is governed by and in accordance with the laws, other than choice of law provision of any particular contract, of South Carolina, including Article 4A of the Uniform Commercial Code as enacted by South Carolina and amended from time to time.
3. The information you provide on the EFT/ERA Enrollment Form is very important. PGBA shall not be liable for any loss which may arise solely by reason of error, mistake, or fraud regarding this information. **You understand that you must communicate any change in this information to PGBA. This communication must be in the form of a new EFT ERA Enrollment Form faxed to this number:**

PGBA, LLC EFT
 Fax: 803-462-3995

4. Payment is initiated within the normal terms of our agreement with you and/or applicable TRICARE procedures. Our EFT terms and conditions neither enlarge nor diminish the parties’ respective rights and obligations within any applicable agreement. The payment due date is not affected. We will consider payment made when your financial institution has received or has control of the payment transaction. This will generally occur within three (3) calendar days following initiation by PGBA. If payment is initiated on a nonbanking day at PGBA’s originating bank, the funds transfer will occur the following banking day. In all cases, “Banking Day” is defined as the day on which both trading partners’ banks are available to transmit and receive these fund transfers.

5. With respect to the EFT reimbursement process, PGBA is responsible up to the point where your financial institution receives or has control of the transaction. Any loss of data at that point will be borne by you unless the loss is due solely to the negligence of PGBA or its originating bank. You hereby represent that you are authorized to enter into this agreement, disburse funds, sign checks, and modify account information for the provider locations listed below.

NAME: _____ SIGNATURE: _____
 (Print)

TITLE: _____ DATE: _____



TRICARE ERA/EFT ENROLLMENT FORM

Transaction Type:

EFT (Electronic Funds Transfer)

ERA (Electronic Remittance Advice)

General Provider Information		
Provider's Name		
Address		
City	State	ZIP
Phone	E-mail Address	
Federal Tax ID	NPI	

Electronic Remittance Advice (ERA) Information
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I hereby authorize _____ to receive
Billing Service/Clearinghouse/Trading Partner

Electronic Remittance Advices (ERA's) on my behalf. I understand that ERA's contain payment information concerning my processed TRICARE claims. I acknowledge that it is my responsibility to notify PGBA, LLC in writing if I wish to revoke this authorization.

EDIG Trading Partner ID/Submitter ID	
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Electronic Funds Transfer (EFT) Information		
Bank Name		
Address		
City	State	ZIP
Bank Contact Name	Phone	
Bank Transit/Routing Number	Account Number	
Type of Account	Saving	Checking

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(s)	
Name/Title <i>(Please Print)</i>	Date
Signature <i>(I am authorized to endorse this enrollment on behalf of my company.)</i>	Phone

This authorization is to remain in full force and effect until PGBA, LLC has received faxed notification of its termination.

