



TRICARE South Region
Claims Department
P .O. Box 7031
Camden. SC 29020-7031

TRICARE South Region
Customer Service Dept.
P .O. Box 7032
Camden, SC 29020-7032

Toll-free: 1-800-403-3950
www.myTRICARE.com by PGBA
Fax 803-462-3986

TRICARE
INSTITUTIONAL PROVIDER APPLICATION

FACILITY NAME: _____

FEDERAL TAX NO: _____ NPI# _____

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

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. ***





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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 Interns/Residents at most recent Fiscal Year end _____

Residential Treatment Centers (RTC), Substance Use Disorder Rehabilitation Facilities (SUDRF) and Psychiatric Partial Hospitalization Programs (PHP) must be certified by the National Quality Monitoring Contract (NQMC-Maximus). Their phone number is: 1-608-308-7160

NQMC- Maximus
1600 E Northern Ave
Ste. 100
Phoenix AZ 85020

HUMANA MILITARY
HEALTHCARE SERVICES



A Legacy of Service



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HEALTH PROGRAM BENEFIT AGREEMENT

In order to receive payment under TRICARE Management Activity (TMA),
_____, dba _____
the provider of services agrees:

(A) To accept as payment for inpatient services provided to eligible beneficiaries, the TRICARE determined allowable amount. This amount will be determined in accordance with the requirements of Title 32 of the Code of Federal Regulations Part 199 (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 1973 as amended, and upon acceptance by the Director, TMA, or his 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 DATE

TITLE 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 AN ASSISTANT SURGEON.

SIGNATURE TITLE DATE

NAME OF FACILITY: _____





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Skilled Nursing Facility
(SNF) Participation Agreement

Agreement between TRICARE and _____(Provider)

doing Business as (DBA)_____

TRICARE Provider ID/Number_____Medicare Provider No._____

NPI#_____

(To be completed by TRICARE Contractor) ~~~~~(To be completed by SNF)

In order to receive payment under 32 Code of Federal Regulations (CFR) Part
199, _____DBA

_____ as the Provider of skilled nursing services, agrees to
conform to the provisions of 32 CFR 199 and applicable provisions in TRICARE Manuals and applicable Medicare
provisions in 42 CFR.

This Agreement, upon submission by the Provider of skilled nursing services 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 TRICARE, shall be binding on the Provider of skilled nursing services and TRICARE.

The Provider of skilled nursing services certifies that:

~~~~a. The Provider is licensed by the State having jurisdiction for the
~~~~~Provider's area.

~~~~b. The Provider is Medicare (or Medicaid) certified and will continue to
~~~~~maintain Medicare certification. If at any time the provider is
~~~~~decertified by Medicare (or Medicaid), the provider agrees to notify the
~~~~~TRICARE contractor within 72 hours. Loss of Medicare (or Medicaid)
~~~~~certification will nullify this agreement. Note: For pediatric SNFs,
~~~~~Medicaid certification will be acceptable in lieu of Medicare
~~~~~certification.

~~~~c. The Provider will not discriminate against the TRICARE beneficiary in
~~~~~their admission practices or in delivery of medically necessary services
~~~~~due to the level of payment.

~~~~d. The Provider will use the same certification forms for TRICARE patients
~~~~~as are used and required for Medicare (or Medicaid) patients.

~~~~e. The Provider will participate on all TRICARE SNF claims and will accept
~~~~~TRICARE payment as the full payment and not balance bill the TRICARE
~~~~~beneficiaries. The Provider will collect the applicable cost-share
~~~~~amounts from the TRICARE beneficiaries.





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In the event of a transfer of ownership, this Agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ACCEPTED FOR THE PROVIDER OF SKILLED NURSING SERVICES BY:

NAME (SIGNATURE)

TITLE-----DATE-----

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SKILLED NURSING SERVICES BY:

NAME (SIGNATURE)

TITLE-----DATE-----

PKEY: 123456789





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

Beginning January 1, 2008, all UB-04 paper claim 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 PGBA, this completed form will be retained and applied for future claim 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: _____

Please fax the completed form to: 803-462-3986

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 Manual 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 80, Remarks, as the location for the signature, if signatures on file requirements do not apply to the claim. If a non-network participating claim does not contain an acceptable signature, return the claim."

