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 PROVIDER FILE APPLICATION

CORPORATION NAME:____

FEDERAL TAX NUMBER:______________________NPI # __________________________

Office Location (Street Address):
____
____

Mailing Address (If different):
____
____

Office Telephone Number:(___)____-_____ Billing Telephone Number:(___)____-_____

PLEASE CHECK APPROPRIATE BOX:

I certify that I have met the following requirements to be reimbursed as a(n):

____ AMBULANCE (Complete Section A)

____ INDEPENDENT CLINICAL LABORATORY (Complete Section B)

____ INDEPENDENT PHYSIOLOGICAL LABORATORY (Complete Section C)

____ PORTABLE X-RAY SUPPLIER (Complete Section D)

____ PHARMACY (Complete Section E)

____ DURABLE MEDICAL EQUIPMENT SUPPLIER (Complete Section E)

____ PARENTERAL AND ENTERAL SUPPLIES (Complete Section E)

____ IMMUNOSUPPRESSANT DRUGS (Complete Section E)

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SECTION E

Date business opened: _____/_____/_____

TYPE OF BUSINESS

_____ Durable Medical Equipment Only	_____ Pharmacy with DME Supplies

_____ Pharmacy Only

TYPE(S) OF SERVICE TO BE BILLED

_____ Durable Medical Equipment Only	_____ Immunosuppressant Drugs

_____ Parenteral/Enteral Supplies	_____ Pharmaceuticals

If pharmacy, give National Pharmacy Number (NABP#) ___________________________

Is the address above also your corporate headquarters? _____ YES _____ NO

If NO, please give name, address, and tax identification number of your corporate headquarters:

_______________________________________	_______________________________
Corporate Name	Corporate Tax I.D. Number

____
NPI #

_______________________________________	_______________________________
Corporate Address	County

_______________________________________	_______________________________
City	State	Zip

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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 ___________________________________ (Please attach a list of any other authorized representatives) 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 where of I have here unto 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 ____/____/____

Per TRICARE Management Activity (TMA) guidelines, we may accept, in lieu of a provider’s actual signature on a TRICARE claim form, a facsimiles signature or signature of a representative if the FI has on file a notarized authorization from the provider for use of a facsimile signature or a notarized authorization of power of attorney for another person to sign on his or her behalf.

The authorized representative may sign using the provider’s name followed by the representative’s initials or using the representative’s own signature followed by “POA” (Power of Attorney), or similar indication of the type of authorization granted by the provider.

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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 TRICARE Management Activity to accept my facsimile or stamp signature shown below 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 full-payment 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

SUBSCRIBED AND SWORN TO BEFORE ME THIS_______DAY OF ________20____

____

NOTARY PUBLIC IN AND FOR

COUNTY OF________________________STATE OF _________________________

(SEAL) MY COMMISSION EXPIRES ____/____/____

Per TMA guidelines, we may accept, in lieu of a provider's actual signature on a TRICARE claim form, a facsimile signature or a signature of a representative if the FI has on file a notarized authorization from the provider for use of a facsimile signature or a notarized authorization of power of attorney for another person to sign on his or her behalf.

The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim form is computer-generated.