



TRICARE Non-Network Physician Assistant Individual Application

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.



License Number: _____

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

Attach a copy of your state license.

Certify that you meet the applicable state requirements governing qualifications for physician assistants and at least one of the following conditions.

____ Currently certified by the National Commission on Certification of the Physician Assistant to assist primary care physician. Attach copy of certification. Or

____ Satisfactorily complete a program for preparing physician assistants that:

- a. Was at least one academic year in length; and
- b. Consisted of supervised clinical practice and at least four months (in the aggregate) of classroom instruction directed toward preparing students to deliver healthcare; and
- c. Was accredited by the American Medical Association's committee on Allied Health Education and Accreditation. Attach copy of completion. Or

____ Satisfactorily completed a formal education program for preparing physician assistants that does not meet the requirements of paragraph two of this section and had been assisting primary care physician for a minimum of twelve months. Attach copy of completion.



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 _____
_____ State _____ Zip Code _____ City _____
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 _____
_____ State _____ Zip Code _____ City _____
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 _____