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
CLINIC OR GROUP PRACTICE
PROFESSIONAL ASSOCIATION, CORPORATION, PARTNERSHIP, CLINIC, ETC

GROUP NAME: ________________________________NPI #__________________

FEDERAL TAX NUMBER:_______________TELEPHONE: (_____)______-________

Office Location (Street Address): Billing Address (If different):

________________________________ ______________________________

________________________________ ______________________________

NOTE: If you use a billing agency, please designate telephone number for billing inquiries: ___________________________

Date legal entity established _____/_____/_____

Are group members all the same specialty? ___ YES ___ NO
If YES, name specialty: ____

Will each Physician sign their own claim form ___ YES ___ NO
IF NO, EACH PHYSICIAN MUST COMPLETE THE ATTACHED SIGNATURE AUTHORIZATION FORMS AND HAVE THEM NOTARIZED.

Do you use a Patient Account Number? ___ YES ___ NO

Do you currently file claims electronically to PGBA, LLC? ___ YES ___ NO If YES, Terminal Number _______________________

IMPORTANT: ALL GROUP MEMBERS MUST COMPLETE AN INDIVIDUAL APPLICATION AND A REASSIGNMENT OF BENEFITS FORM.

PLEASE complete one application for EACH location.

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ATTACH A PHOTOCOPY OF YOUR LICENSE OR CERTIFICATION

License No:____________________________Issuing State: _____________________

Original License Date: __________________________________

Current License Effective Dates: From _________________To ____________________

CONFLICT OF INTEREST STATEMENT

"Federal Law (5 U.S.C. 5536) prohibits medical personnel who are active duty members or civilian employees of government from receiving additional government compensation above their normal pay and allowance for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. Claims for TRICARE benefits will be denied where either a uniformed member or civilian employee of the uniformed services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selective basis."

_____________________________________ _____________________________
Signature of Applicant Signature Date

"I, the undersigned provider, in submitting this application for certification as an authorized provider under the TRICARE program, do affirm and attest that the information which I have provided in response to and support of this application is true and correct. I understand that any misrepresentation of my credentials which bear upon my qualification for authorized TRICARE provider status may be subject to the Administrative Remedies for Fraud, Abuse and Conflict of Interest as defined in 32 CFR 199.9."

_____________________________________ _____________________________
Signature of Applicant Signature Date

Please notify Provider Certification of any changes related to your provider file information (name, address, specialty, tax number, group affiliations, etc.).

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GROUP MEMBER LISTING

Please list all of the MEDICAL DOCTORS (MD'S) and OSTEOPATHS (DO'S) affiliated with your group.

PLEASE COMPLETE ALL REQUIRED INFORMATION AND RETURN WITH COPY OF PROFESSIONAL LICENSES, COVER LETTER AND APPLICATION.

PHYSICIAN NAME (LAST, FIRST, MID)	SSN AND NPI NUMBERS	LICENSE NUMBER	PRIMARY SPECIALTY	DATE MD/DO JOINED GRP

1. ________________ _______/__________ ___________ ___________ ___________
(SSN / NPI)
ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES:__/__/__ TO __/__/__

2. ________________ _______/__________ ___________ ___________ ___________
(SSN / NPI)
ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES:__/__/__ TO __/__/__

3. ________________ _______/__________ ___________ ___________ ___________
(SSN / NPI)
ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES:__/__/__ TO __/__/__

4. ________________ _______/__________ ___________ ___________ ___________
(SSN / NPI)
ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES:__/__/__ TO __/__/__

5. ________________ _______/__________ ___________ ___________ ___________
(SSN / NPI)
ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES:__/__/__ TO __/__/__

6. ________________ _______/__________ ___________ ___________ ___________
(SSN / NPI)
ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES:__/__/__ TO __/__/__

7. ________________ _______/__________ ___________ ___________ ___________
(SSN / NPI)
ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES:__/__/__ TO __/__/__

8. ________________ _______/__________ ___________ ___________ ___________
(SSN / NPI)
ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES:__/__/__ TO __/__/__

PLEASE PHOTOCOPY THIS FORM IF YOU HAVE MORE THAN EIGHT PHYSICIANS IN YOUR GROUP.

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SECTION E

_____ I am a licensed registered nurse and I have at least a master's degree in nursing with a specialization in psychiatric and mental health nursing (ATTACH COPY OF DEGREE):

NAME OF SCHOOL: ____

DEGREE:_________________DISCIPLINE:____________YEAR GRADUATED: _____

ATTACH COPY OF RN LICENSE AS WELL AS PSYCHIATRIC AND MENTAL HEALTH NURSING ASSOCIATION ACCREDITATION.

_____ I have had at least two (2) years of post-master's degree practice in the field of psychiatric and mental health nursing including an average of eight (8) hours of direct patient contact per week. Date experience requirement was met: ____/____/____

OR
_____ I am listed in a TRICARE-recognized, professionally sanctioned listing of clinical specialists in psychiatric and mental health nursing.

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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 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 _____/_____/_____

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.

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PHYSICIAN AUTHORIZATION FOR REASSIGNMENT OF BENEFITS TO CLINIC

TRICARE
PGBA, LLC

It is agreed that ____
(Name of Clinic, Group or Professional Association)

will bill for and receive any charges or fees for the services of

____.
(Name of Provider)

____
(Office Address)

____

____________________________________ ____________________________________
Signature-Authorized Individual for Clinic | Signature of Provider

____________________________________ ____________________________________
Employer Identification Number | Social Security Number

____________________________________ ____________________________________
NPI# for Employer Identification Number | NPI# for Social Security Number

____________________________________ ____________________________________
Date | Date

Date individual joined group practice: ___________________

Please return to the address indicated at the top of this letter.