



TRICARE South Region
 Provider Data Management
 P.O. Box 7039
 Camden, SC 29020-7039
 Fax: 803-462-3992

Toll-Free: 1-800-403-3950

TRICARE 'LIMITED' PROVIDER FILE APPLICATION

NAME: _____ **SOCIAL SECURITY NUMBER:** _____

NPI# _____

IF YOU ARE SOLO INCORPORATED, PLEASE GIVE EIN NUMBER: _____

Office Location (Street Address):

Payment Address (If different):

Office Telephone No: (____) ____-_____

Payment Telephone No: (____) ____-_____

If you file your taxes under a Federal Employer Identification Number because you belong to an incorporated group/professional association, you must also complete a GROUP APPLICATION and the enclosed REASSIGNMENT OF BENEFIT FORM.

Are you a member of an established group practice or institution? _____ YES _____ NO

If YES, Practice Name: _____ **Provider Number:** _____

Date you began employment with group number: ____/____/____

Do you maintain a solo practice? _____ YES _____ NO

I will be signing my own claim forms: _____ YES _____ NO

If NO, then the enclosed Facsimile Signature Authorization Form(s) must be completed.

I certify that all applicable licensing and other regulatory requirements that are extant in that state, county, municipality, or other political jurisdiction in which the ECHO service is rendered to be reimbursed as a(n):

_____.



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ATTACH A PHOTOCOPY OF YOUR LICENSE OR CERTIFICATION

Are you currently certified by BACB (Behavioral Analyst Certification Board):

Yes _____ No _____

BACB Certification No: _____

Are you currently State certified or licensed:

Yes ___ No ___

CONFLICT OF INTEREST STATEMENT

“Federal Law (5 U.S.C. 5536) prohibits medical personnel who are active duty members or civilian employees of the 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 spouse/beneficiary. Claims for TRICARE benefits will be denied whether 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 ECHO program, do affirm and attest that the information which I have provided in response to support of this application is true and correct. I understand that any misrepresentation of my credentials which bear upon my qualification for authorized TRICARE ECHO provider status may be subject to the administrative Remedies for Fraud, Abuse and Conflict of Interest as defined in Chapter 9 of the TRICARE Regulation, DoD 6010.8-R and/or 32 CFR 199.9.

 Signature of Applicant

 Signature Date

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





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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 Contractor for the TRICARE in the state of _____ to accept my facsimile or stamp signature shown below as my true 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

 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 TRICARE Management Activity (TMA) guidelines, we may accept in lieu of a provider's actual signature on a TRICARE claim form, a facsimile signature. The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim 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)

 (Address)

 Authorized Signature for Clinic

 Signature of Provider

 Employer Identification Number

_____/_____
 Social Security Number NPI#

 Date

 Date

Date Individual joined group practice _____

Please return to the address listed below.

PLEASE RETURN FORMS TO:
PGBA, LLC
TRICARE Extended Care Health Option
PO Box 7036
Camden SC 29020-7036





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**TRICARE PROVIDER FILE APPLICATION
CLINIC OR GROUP PRACTICE
PROFESSIONAL ASSOCIATION, CORPORATION, PARTNERSHIP, CLINIC, ETC.**

GROUP NAME: _____

FEDERAL TAX NUMBER: _____ **NPI#** _____

Office Tele. No: (____) _____ - _____

Billing Tele. No: (____) _____ - _____

Office Location (Street Address):

Mailing Address (If different):

Date legal entity established ____/____/____

Are group members all the same specialty? _____ **YES** _____ **NO**

If YES, name the specialty: _____

Will each provider sign his or her own claim form? _____ **YES** _____ **NO**

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



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GROUP MEMBER LISTING

Please list all of the rendering providers associated with your group.

PLEASE COMPLETE ALL FIELDS AND RETURN WITH COVER LETTER AND APPLICATION.

NAME Last, First, MI	SSN AND NPI NUMBERS	CERTF/LICENSE NUMBER	PRIMARY SPECIALTY	DATE JOINED GROUP