



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
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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 H  
CERTIFIED NURSE ANESTHETISTS

Provider Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

RN License Information: ATTACH A COPY OF LICENSE.

License No.: \_\_\_\_\_ Issuing State: \_\_\_\_\_

Original Issue Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

ATTACH A PHOTOCOPY OF THE CARD ISSUED TO YOU by either the Council on Certification of Nurse Anesthetists or by the Council on Recertification of Nurse Anesthetists.

Certification No.: \_\_\_\_\_ Issuing State: \_\_\_\_\_

Original Certification Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Preceptor(s) (Supervising Physician) for practice:

\_\_\_\_\_

\_\_\_\_\_

Highest degree level: \_\_\_\_\_

Institution: \_\_\_\_\_

I understand that continued privileges are contingent on continued certification by either the Council on Certification on Nurse Anesthetists or by the Council on Recertification.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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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.

