TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039
Fax 803-462-3986

Toll-Free: 1-800-403-3950

Application for TRICARE-Provider Status

CORPORATE SERVICES PROVIDER

The public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0020), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

DIRECTIONS

To apply for certification as a TRICARE-authorized provider, read and complete all sections of this application and return it with all attachments to the following address:

PGBA, LLC
Provider Data Management
PO BOX 7039
Camden SC 29020-7039

For inquiries, please call 1-800-403-3950
NOTE: All Applications must be signed by the Chief Executive Officer and dated.

The above named provider has applied to become a TRICARE-authorized provider. The signee certifies that the information in this application and attachments is true and accurately represents and depicts the above-named provider.

Sincerely,
Provider Data Management

______________________________ ____________________
Chief Executive Officer Date

TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039
Fax 803-462-3986

Toll-Free: 1-800-403-3950

Application for TRICARE-Provider Status:

INSTITUTION/CORPORATE SERVICES PROVIDER

PLEASE CHECK APPROPRIATE BOX:

____RADIATION THERAPY

____CARDIAC CATHETERIZATION CLINIC

____FREESTANDING SLEEP DISORDER DIAGNOSTIC CENTER

____INDEPENDENT PHYSIOLOGICAL LABORATORIES

____FREESTANDING KIDNEY DIALYSIS CENTER

____FREESTANDING MRI CENTERS

____COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

____HOME HEALTH AGENCY

____FREESTANDING BONE MARROW TRANSPLANT CENTER

____HOME INFUSION

____DIABETIC OUTPUT SELF MANAGEMENT EDUCATION PROGRAM

Identification Information:

Name: ____

Corporate/foundation name if different:_______________________________________

ADDRESS:

Physical Location (Street, city, state, ZIP):	Mailing Address (if different)
____________________________	______________________________
____________________________	______________________________
____________________________	______________________________
____________________________	______________________________
____________________________	______________________________

TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039
Fax 803-462-3986

Toll-Free: 1-800-403-3950

Area code and TELEPHONE NUMBER: ______________________________

Area code and FACSIMILE NUMBER ______________________________

TAX ID NUMBER: ________________________

NPI#___________________________________

Are you a MEDICARE provider? Yes______No_______

If yes: Medicare certification number: ______________________________

Medicare Category: ______________________________

Medicare acceptance date: ______________________________

How will you bill? ______Professional

______Technical

______Global

Are you JCAHO accredited? Yes______ No_________

If yes: JCAHO classification: ____________________________

Original JCAHO classification date: ___________________________________

Current JCAHO classification dates FROM: _____________________________

TO: ___________________________________

STATE license classification: ____

Dates of state licensure FROM: _____________________________

TO: __________________________________

Are you certified by national board? Yes______ No________

If yes: Name of board: _____________________________

Effective date of certification: ___________________________________

IMPORTANT: Please attach copies of applicable Medicare, JCAHO, state and national board certificates/licenses.

TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039
Fax 803-462-3986

Toll-Free: 1-800-403-3950

PARTICIPATION AGREEMENT

In order to receive payment under TRICARE, ____

dba___________________________________, as the provider of services agrees:

1. Not to charge a beneficiary for the following:

   a. Services for which the provider is entitled to payment from TRICARE;

   b. Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements;

   c. Services not medically necessary and appropriate for the clinical management of the presenting illness, injury, disorder or maternity;

   d. Services for which a beneficiary would be entitled to payment but for a reduction or denial in payment as a result of quality review; and

   e. Services rendered during a period in which the provider was not in compliance with one or more conditions of authorization:

2. To comply with applicable provisions of 32 CFR 199 and related TRICARE policy;

3. To accept the TRICARE determined allowable payment combined with the cost-share, deductible, and other health insurance a amounts payable by, or on behalf of, the beneficiary, as full payment for TRICARE allowed services;

4. To collect from the TRICARE beneficiary those amounts that the beneficiary has a liability to pay for the TRICARE deductible and cost-share/co-payment;

5. To permit access by the Executive Director, TMA, or designee, to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state or private agencies or organizations;

6. To provide to the Executive Director, TMA, or designee (e.g., Managed Care Support Contractor), prompt written notification of the provider's employment of an individual who, at any time during the twelve months preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly, or indirectly, for decisions regarding Department of Defense payments to the provider;

7. To cooperate fully with a designated utilization and clinical quality management organization which has a contract with the Department of Defense for the geographic area in which the provider renders services;

8. Comply with all applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/ co-payment may be expected;

9. To maintain clinical and other records related to individuals for whom TRICARE payment was made for services rendered by the provider, or otherwise under arrangement, for a period of 60 months from the date of service;

10. To maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, the methods, modalities or means of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment;

11. To refer TRICARE beneficiaries only to providers with which the referring provider does not have an economic interest, as defined in 32 CFR 199.2;

12. To limit services furnished under arrangement to those for which receipt of payment by the TRICARE authorized provider discharges the payment liability of the beneficiary; and

13. Meet such other requirements as the Secretary of Defense may find necessary in the interest of health and safety of the individuals who are provided care and services.

TRICARE Management Activity (TMA) agrees to:

Pay the above-named provider the full allowable amount less any applicable double-coverage, cost-share/co-payment, and deductible amounts.

This agreement shall be binding on the provider and TMA upon acceptance by the Executive Director, TMA, or designee.

This agreement shall be effective until terminated by either party. The effective date shall be the date the agreement is signed by TMA.

This agreement may be terminated by either party by giving the other party written notice of termination. The provider shall also provide written notice to the public. Such notice of termination is to be received by the other party no later than 45 days prior to the date of termination. In the event of transfer of ownership, this agreement is assigned to the new owner, subject to the conditions specified in this agreement and pertinent regulations.

FOR PROVIDER OF SERVICES BY:	FOR TMA BY:
______________________	______________________
Name	Name
______________________	______________________
Title Date	Title Date

TERMS AND CONDITIONS FOR ELECTRONIC FUNDS TRANSFER

By Signing below your company agrees to accept payment by PGBA, LLC (PGBA) through electronic funds transfer (EFT). Additionally, you acknowledge and agree that all payments shall be made in accordance with the information that you supply on the Electronic Funds Transfer Authorization Form and that PGBA shall be entitled to rely exclusively upon such information. This agreement applies to and amends all existing agreements with PGBA by incorporating the following terms and conditions for electronic payment. PGBA will initiate payment to you based on the following:

1. PBGA will transfer funds electronically to the financial institution and account number you register on the attached EFT/ERA Enrollment Form.

2. PGBA will make payments in accordance with and be governed by the National Automated Clearinghouse Association's Corporation Trade Payment Rules. Our process is governed by and in accordance with the laws, other than choice of law provision of any particular contract, of South Carolina, including Article 4A of the Uniform Commercial Code as enacted by South Carolina and amended from time to time.

3. The information you provide on the EFT/ERA Enrollment Form is very important. PGBA shall not be liable for any loss which may arise solely by reason of error, mistake, or fraud regarding this information. **You understand that you must communicate any change in this information to PGBA. This communication must be in the form of a new EFT ERA Enrollment Form faxed to this number:**

   PGBA, LLC EFT
   Fax: 803-462-3995

4. Payment is initiated within the normal terms of our agreement with you and/or applicable TRICARE procedures. Our EFT terms and conditions neither enlarge nor diminish the parties' respective rights and obligations within any applicable agreement. The payment due date is not affected. We will consider payment made when your financial institution has received or has control of the payment transaction. This will generally occur within three (3) calendar days following initiation by PGBA. If payment is initiated on a nonbanking day at PGBA's originating bank, the funds transfer will occur the following banking day. In all cases, "Banking Day" is defined as the day on which both trading partners' banks are available to transmit and receive these fund transfers.

5. With respect to the EFT reimbursement process, PGBA is responsible up to the point where your financial institution receives or has control of the transaction. Any loss of data at that point will be borne by you unless the loss is due solely to the negligence of PGBA or its originating bank.

You hereby represent that you are authorized to enter into this agreement, disburse funds, sign checks, and modify account information for the provider locations listed below.

NAME: ______________________________________ SIGNATURE: ______________________________________
(Print)
TITLE: ____ DATE: __________________________

TRICARE ERA/EFT ENROLLMENT FORM

Transaction Type: **EFT (Electronic Funds Transfer)** **ERA (Electronic Remittance Advice)**

General Provider Information		
Provider's Name		
Address		
City State		ZIP
Phone E-m	ail Address	
Federal Tax ID	NPI	

Electronic Remittance Advice (ERA) Information

I hereby authorize ______________________________ to receive
Billing Service/Clearinghouse/Trading Partner

Electronic Remittance Advices (ERA's) on my behalf. I understand that ERA's contain payment information concerning my processed TRICARE claims. I acknowledge that it is my responsibility to notify PGBA, LLC in writing if I wish to revoke this authorization.

EDIG Trading Partner ID/Submitter ID	

Electronic Funds Transfer (EFT) Information		
Bank Name		
Address		
City State		ZIP
Bank Contact Name	Phone	
Bank Transit/Routing Number	Account Number	
Type of Account	Saving	Checking

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(s)	
Name/Title (*Please Print*) Date	
Signature (*I am authorized to endorse this enrollment on behalf of my company.*)	Phone

This authorization is to remain in full force and effect until PGBA, LLC has received faxed notification of its termination.

If your corporate headquarters will be receiving ERA's/EFT's for satellite offices, please list them below.

TRICARE Provider Number (with suffix)	**National Provider Identifier (NPI #)**	**Business Name and Address**

.