



**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.  
Attn: TRICARE Provider Data Management  
P.O. Box 870156  
Surfside Beach, SC 29587-9756  
OR  
Fax 1-888-279-3540

For inquiries, please call the toll-free 1-877-TRICARE.

Provider name: \_\_\_\_\_

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.

\_\_\_\_\_  
Chief Executive Officer

\_\_\_\_\_  
Date

PGBA, LLC  
Provider Management  
P.O. Box 870156  
Surfside Beach, SC 29587-9756  
1-877-TRICARE (1-877-874-2273)  
Fax 1-888-279-3540



## TRICARE CORPORATE SERVICE PROVIDER APPLICATION

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

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**TRICARE CORPORATE SERVICES PROVIDER APPLICATION**

FACILITY NAME: \_\_\_\_\_

CORPORATE/FOUNDATION NAME IF DIFFERENT: \_\_\_\_\_

FEDERAL TAX ID NO: \_\_\_\_\_ NPI# \_\_\_\_\_

Telephone number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Facsimile number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

PHYSICAL LOCATION (Street Address) MAILING ADDRESS (If different):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you a MEDICARE provider? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes: MEDICARE Certification no: \_\_\_\_\_

MEDICARE CATEGORY: \_\_\_\_\_

MEDICARE ACCEPTANCE DATE: \_\_\_\_\_

Are you JCAHO accredited? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes: JCAHO classification: \_\_\_\_\_

Original classification date: \_\_\_\_\_

Current JCAHO classification dates FROM: \_\_\_\_\_ TO: \_\_\_\_\_

STATE License classification: \_\_\_\_\_

Dates of state licensure FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Are you certified by a national board? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes: Name of board: \_\_\_\_\_ Effective date of certification: \_\_\_\_\_

NOTE: You must attach a copy of your Medicare, JCAHO, State, and National Board Certificates/Licenses.

## 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 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;

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**ELECTRONIC FUNDS TRANSFER (EFT)**

Complete and FAX/Mail to: TRICARE North EFT, PO Box 870154, Surfside Beach, SC 29587-9754. (For assistance contact our EDI Help desk at, 1-877-334-2524). Or FAX completed form to 1-843-215-7304. Thank You

**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, debt 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.

\_\_\_\_\_  
(person with signature authority) Date Signature