	TRICARE South Region Provider Data Mgmt. Dept. P.O Box 7039 Camden, SC 29020-7039 Fax 803-462-3986	1-800-403-3950
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TRICARE PROVIDER FILE APPLICATION

CORPORATION NAME: _____

FEDERAL TAX NUMBER: _____ NPI# _____


Office Location (Street Address): _____ Mailing Address (If different): _____

Office Telephone Number: (____)____ - _____ Billing Telephone Number: (____)____ - _____

PLEASE CHECK APPROPRIATE BOX:

I certify that I have met the following requirements to be reimbursed as a(n):

- ___ AMBULANCE (Complete Section A)
- ___ INDEPENDENT CLINICAL LABORATORY (Complete Section B)
- ___ INDEPENDENT PHYSIOLOGICAL LABORATORY (Complete Section C)
- ___ PORTABLE X-RAY SUPPLIER (Complete Section D)
- ___ PHARMACY (Complete Section E)
- ___ DURABLE MEDICAL EQUIPMENT SUPPLIER (Complete Section E)
- ___ PARENTERAL AND ENTERAL SUPPLIES (Complete Section E)
- ___ IMMUNOSUPPRESSANT DRUGS (Complete Section E)

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SECTION A

License No: _____ Issuing State: _____

Date: ____/____/____

Is license _____ TEMPORARY _____ PERMANENT

ATTACH A COPY OF YOUR LICENSE AND/OR CERTIFICATION.


If your state does not offer licensure you must include a signed and dated statement on letterhead by an official of the organization operating the ambulance service stating that (1) there is no license requirement for the operation of an ambulance service within the geographic area served by the ambulance service, or (2) that the organization is exempt from a license requirement for the operation of an ambulance service with an explanation of the legal basis for exemption.

PLEASE CHECK APPROPRIATE BOXES: I certify that the above-named ambulance company meets the following requirements:

- ___ Each of the company's ambulance vehicles are specially designed and equipped for emergency transportation of the sick and injured, AND
- ___ The minimum ambulance crew consists of at least two members, one of whom must have a minimum training at least equivalent to that provided by the Red Cross first aid course.
- ___ The ambulance company agrees to notify PGBA, LLC of any change in company ownership and/or operation which results in:
 1. The use of vehicles as ambulances which are specially designed and equipped for emergency transportation of the sick and injured, OR
 2. When the minimum first aid requirement for crew members is less than that of the advanced Red Cross first aid course equivalent, OR
 3. When the political jurisdiction in which the ambulance company is based requires a license to operate an ambulance service within their jurisdiction.

 SIGNATURE TITLE DATE

Please Return To: TRICARE
 Provider Data Management
 PO Box 7039
 Camden, SC 29020-7039

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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 where of I have here unto 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.