



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  
 INSTITUTIONAL PROVIDER APPLICATION

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

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

Office Telephone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Billing Telephone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_

OFFICE LOCATION (Street Address): \_\_\_\_\_ MAILING ADDRESS (If Different): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is the facility Medicare certified: \_\_\_\_\_ YES \_\_\_\_\_ NO If yes:

CERTIFICATION NUMBER (Original): \_\_\_\_\_ CATEGORY: \_\_\_\_\_

ORIGINAL CERTIFICATION DATE: \_\_\_/\_\_\_/\_\_\_

CURRENT CERTIFICATION DATES: \_\_\_/\_\_\_/\_\_\_ TO \_\_\_/\_\_\_/\_\_\_

Is the facility JCAHO certified: \_\_\_\_\_ YES \_\_\_\_\_ NO If yes:

JCAHO CLASSIFICATION: \_\_\_\_\_

ORIGINAL CLASS. DATE: \_\_\_/\_\_\_/\_\_\_

CURRENT CLASS. DATES: \_\_\_/\_\_\_/\_\_\_ TO \_\_\_/\_\_\_/\_\_\_

STATE LICENSE CLASSIFICATION (Original): \_\_\_\_\_

ORIGINAL LICENSE DATE: \_\_\_/\_\_\_/\_\_\_

CURRENT LICENSE DATES: \_\_\_/\_\_\_/\_\_\_ TO \_\_\_/\_\_\_/\_\_\_

\*\*\*YOU MUST ATTACH COPIES OF MEDICARE, JCAHO AND STATE LICENSING.\*\*\*





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Is your facility classified as a:

\_\_\_\_\_ Sole Community Hospital (attach proof of Medicare Classification)

\_\_\_\_\_ Children's Hospital

\_\_\_\_\_ Teaching Facility, Please complete the following:

Number of Beds, excluding exempt unit \_\_\_\_\_

Number of Intern/Residents at most recent Fiscal Year end \_\_\_\_\_

Residential Treatment Facilities (RTC), Partial Hospitalization Program (PHP) and Substance Use Disorder Rehabilitation Facilities (SUDRF) must be certified by:

NQMC-MAXIMUS, Inc.  
1600 E. Northern Avenue  
Suite 100  
Phoenix, AZ 85020  
Phone: 602-308-7160  
E-mail: nqmc@maximus.com



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### HEALTH PROGRAM BENEFIT AGREEMENT

In order to receive payment under TRICARE, \_\_\_\_\_  
 dba \_\_\_\_\_ as the provider of services agrees:

(A) To accept as payment for inpatient services provided to eligible beneficiaries, the TRICARE-determined allowable amount will be determined in accordance with the requirements of 32 CFR 199.

(B) To refrain from billing the TRICARE-eligible beneficiary for amounts, which exceed the TRICARE-determined allowable amount except for, services not covered by TRICARE as described in 32 CFR 199 and for amounts which constitute the TRICARE beneficiary's liability for cost-share and deductible.

TMA agrees:

(A) To pay the hospital the full allowable amount less any applicable cost-share and deductible amounts.

This agreement shall be binding on the provider and TMA upon submission by the provider of acceptable assurance of compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Director, TMA, or a designee.

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

The agreement may be terminated by either party by giving the other party written notice of termination. Such notice of termination is to be received by the other party no later than 30 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 TRICARE Management Activity By:

\_\_\_\_\_  
 NAME

\_\_\_\_\_  
 NAME

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 DATE





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An Assistant Surgeon is a physician, dentist or podiatrist, certified physician assistant or certified nurse midwife acting within the scope of their license, who actively assists the operating surgeon in the performance of a covered surgical service. TRICARE benefits are allowable only when the assistant surgeon is considered **MEDICALLY NECESSARY**. Services of an assistant surgeon are considered medically necessary when the surgical procedure is of the complexity and seriousness as to warrant a surgical assistant (other than the surgical nurse or other such operating room personnel) and, interns, residents or other hospital staff are **NOT** available to provide surgical assistance.

The operating surgeon must certify in writing to the nonavailability of a qualified intern, resident, or other hospital physician. In lieu of the operating surgeon's certification, the hospital may certify that they do not have internal staff available at any time to perform the services of assistant surgeons.

If the statement below pertains to your facility, we will document our files accordingly. Please return this form with the signature of an authorized hospital representative with the enclosed application package.

I \_\_\_\_\_, CERTIFY THAT THE FACILITY NOTED ABOVE HAS NO INTERNAL STAFF AVAILABLE AT ANY TIME TO PERFORM THE SERVICES OF AN ASSISTANT SURGEON.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE



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### UB-04 "Signature on File Form" For TRICARE Claims

Beginning January 1, 2008, all UB-04 paper claim submissions for TRICARE must include a signature on the claim form in order to process. The provider signature should be applied in the "Remarks Field" (FL80) of the UB-04 claim form.

However, if you would like to eliminate the need to apply a signature in the remarks field on each and every claim submitted please complete this form and return it to the fax number provided.

IN order to prevent delays in processing your TRICARE claims we are offering this "Signature on File Form."

Please provide the information requested below and fax this form to the PGBA fax number listed. Once received at PGBA, this completed form will be retained and applied for future claim submissions from your facility thus eliminating the need to apply a signature to each individual claim filed.

Facility Name: \_\_\_\_\_

Facility Tax Identification Number: \_\_\_\_\_

Signature of Authorized  
Representative: \_\_\_\_\_

Please fax the completed form to: 803-462-3986

Signature on this form certifies that any changes submitted by the facility on a UB-04 are true, accurate and correct. Signature on this form meets the policy requirement from TRICARE Operations Manual Chapter 8, Section 10, as stated below and negates the need for a signature in block 80 of the UB-04.

"The signature of the non-network provider, or an acceptable facsimile, is required on all participating claims. The provider's signature block Form Locator (FL) has been eliminated from the CMS 1450 UB-04. As a work around, the National Uniform Billing Committee (NUBC) has designated FL 80, Remarks, as the location for the signature, if signatures on file requirements do not apply to the claim. If a non-network participating claim does not contain an acceptable signature, return the claim."

