



TRICARE South Region
 Provider Data Management
 P.O. Box 7039
 Camden, SC 29020-7039
 Fax: 803-462-3992

Toll-Free: 1-800-403-3950

TRICARE 'LIMITED' PROVIDER FILE APPLICATION

NAME: _____ **SOCIAL SECURITY NUMBER:** _____

NPI# _____

IF YOU ARE SOLO INCORPORATED, PLEASE GIVE EIN NUMBER: _____

Office Location (Street Address):

Payment Address (If different):

Office Telephone No: (____) ____-_____

Payment Telephone No: (____) ____-_____

If you file your taxes under a Federal Employer Identification Number because you belong to an incorporated group/professional association, you must also complete a GROUP APPLICATION and the enclosed REASSIGNMENT OF BENEFIT FORM.

Are you a member of an established group practice or institution? _____ YES _____ NO

If YES, Practice Name: _____ **Provider Number:** _____

Date you began employment with group number: ____/____/____

Do you maintain a solo practice? _____ YES _____ NO

I will be signing my own claim forms: _____ YES _____ NO

If NO, then the enclosed Facsimile Signature Authorization Form(s) must be completed.

I certify that all applicable licensing and other regulatory requirements that are extant in that state, county, municipality, or other political jurisdiction in which the ECHO service is rendered to be reimbursed as a(n):

_____.





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ATTACH A PHOTOCOPY OF YOUR LICENSE OR CERTIFICATION

Are you currently certified by BACB (Behavioral Analyst Certification Board):

Yes _____ No _____

BACB Certification No: _____

Are you currently State certified or licensed:

Yes ___ No ___

CONFLICT OF INTEREST STATEMENT

“Federal Law (5 U.S.C. 5536) prohibits medical personnel who are active duty members or civilian employees of the 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 spouse/beneficiary. Claims for TRICARE benefits will be denied whether 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 ECHO program, do affirm and attest that the information which I have provided in response to support of this application is true and correct. I understand that any misrepresentation of my credentials which bear upon my qualification for authorized TRICARE ECHO provider status may be subject to the administrative Remedies for Fraud, Abuse and Conflict of Interest as defined in Chapter 9 of the TRICARE Regulation, DoD 6010.8-R and/or 32 CFR 199.9.

 Signature of Applicant

 Signature Date

Please notify us of any changes, related to your provider file information (name, address, specialty, tax number, group affiliations, etc.).





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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 Contractor for the TRICARE in the state of _____ to accept my facsimile or stamp signature shown below as my true signature, including my agreeing to abide by the TRICARE payment system 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 TRICARE Management Activity (TMA) guidelines, we may accept in lieu of a provider's actual signature on a TRICARE claim form, a facsimile signature. The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim 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)

 (Address)

 Authorized Signature for Clinic

 Signature of Provider

 Employer Identification Number

_____/_____
 Social Security Number NPI#

 Date

 Date

Date Individual joined group practice _____

Please return to the address listed below.

PLEASE RETURN FORMS TO:
PGBA, LLC
TRICARE Extended Care Health Option
PO Box 7036
Camden SC 29020-7036





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**TRICARE PROVIDER FILE APPLICATION
 CLINIC OR GROUP PRACTICE
 PROFESSIONAL ASSOCIATION, CORPORATION, PARTNERSHIP, CLINIC, ETC.**

GROUP NAME: _____

FEDERAL TAX NUMBER: _____ **NPI#** _____

Office Tele. No: (____) _____ - _____

Billing Tele. No: (____) _____ - _____

Office Location (Street Address):

Mailing Address (If different):

Date legal entity established ____/____/____

Are group members all the same specialty? _____ **YES** _____ **NO**

If YES, name the specialty: _____

Will each provider sign his or her own claim form? _____ **YES** _____ **NO**

IMPORTANT: ALL GROUP MEMBERS MUST COMPELTE AN INDIVIDUAL APPLICATION AND A REASSIGNMENT OF BENEFITS FORM.





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GROUP MEMBER LISTING

Please list all of the rendering providers associated with your group.

PLEASE COMPLETE ALL FIELDS AND RETURN WITH COVER LETTER AND APPLICATION.

NAME Last, First, MI	SSN AND NPI NUMBERS	CERTF/LICENSE NUMBER	PRIMARY SPECIALTY	DATE JOINED GROUP



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. PGBA 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-mail Address	
Federal Tax ID	NPI	

Electronic Remittance Advice (ERA) Information
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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	
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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 (<i>Please Print</i>)	Date
Signature (<i>I am authorized to endorse this enrollment on behalf of my company.</i>)	Phone

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

