



TRICARE Program
 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

**NON-NETWORK TRICARE PROVIDER FILE APPLICATION
 CLINIC OR GROUP PRACTICE
 PROFESSIONAL ASSOCIATION, CORPORATION, PARTNERSHIP, CLINIC, ETC**

GROUP NAME: _____

FEDERAL TAX NUMBER: _____

Group NPI# _____

Office Location (Street Address): _____

Mailing Address (If different): _____

Telephone No: _____

Telephone No: _____

Fax Number: _____

E-mail Address: _____

Date legal entity established ____/____/____

PLEASE complete one application for EACH location.

NOTE: If you use a billing agency, please designate telephone number for billing inquiries: _____

Are group members all the same specialty? ___ YES ___ NO

If YES, name specialty: _____

Will each Physician sign their own claim form ___ YES ___ NO

If No, Signature Authorization forms are attached. Please complete these forms and have them notarized.





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GROUP MEMBER LISTING

Please list all of the Providers affiliated with your group.

PLEASE COMPLETE ALL REQUIRED INFORMATION AND RETURN WITH COPY OF PROFESSIONAL LICENSES, COVER LETTER AND APPLICATION.

PHYSICIAN NAME (LAST, FIRST, MID)	SSN NUMBER	NPI NUMBER	PRIMARY SPECIALTY	DATE JOINED GRP
1. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: __/__/__ EXPIRATION DATE: __/__/__				
2. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: __/__/__ EXPIRATION DATE: __/__/__				
3. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: __/__/__ EXPIRATION DATE: __/__/__				
4. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: __/__/__ EXPIRATION DATE: __/__/__				
5. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: __/__/__ EXPIRATION DATE: __/__/__				
6. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: __/__/__ EXPIRATION DATE: __/__/__				
7. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: __/__/__ EXPIRATION DATE: __/__/__				
8. _____	_____	_____	_____	_____
LICENSE NUMBER: _____ ORIGINAL DATE: __/__/__ EXPIRATION DATE: __/__/__				

PLEASE PHOTOCOPY THIS FORM IF YOU HAVE MORE THAN EIGHT PHYSICIANS IN YOUR GROUP.





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MENTAL HEALTH COUNSELOR

Each Mental Health Counselor needs to complete the information listed below. Failure to complete all applicable parts of this section will result in delay and/or denial of certification.

Provider Name: _____

License Number: _____

Original License Date: ____/____/____ Current Expiration Date: ____/____/____

1. Attach a copy of your state license
2. Attach a copy of your Master's Degree

Date Graduated: ____/____/____ Degree Type: _____

Name of University: _____

3. Have had a minimum of two years post-Master's experience, which includes 3000 hours of clinical work and 100 hours of face-to-face supervision.
____ Yes ____ No



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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 Fiscal Intermediary for the TRICARE Management Activity Office, (TRICARE) in the State of South Carolina 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/VA 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.





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PROVIDER’S NOTARIZED SIGNATURE AUTHORIZATION

STATE OF _____ COUNTY OF _____

Know all person 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 the TRICARE Management Activity Office (TMA). My signature by my said Attorney-In-Fact includes my agreement to abide by the full payment concept and remainder of the certification appearing on all TRICARE/VA 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 whereof I have hereunto 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 COMMISION 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 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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ELECTRONIC FUNDS TRANSFER (EFT)

Complete and FAX/Mail to: TRICARE North EFT, PO Box 870154, Surfside Beach, SC 29587-9754 or FAX completed form to 1-888-536-2324. (For assistance contact our EDI Help desk at, 1-877-334-2524).

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, 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 (person with signature authority) _____ Date _____

