



**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 \_\_\_\_\_

