



TRICARE South Region  
Claims Department  
P .0. Box 7031  
Camden. SC 29020-7031

TRICARE South Region  
Customer Service Dept.  
P .0. Box 7032  
Camden, SC 29020-7032

Toll-free: 1-800-403-3950  
www.myTRICARE.com by PGBA  
Fax 803-462-3986

TRICARE  
INSTITUTIONAL PROVIDER APPLICATION

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

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

Office Tele. No:(\_\_\_\_)\_\_\_\_-\_\_\_\_ Billing Tele. No:(\_\_\_\_)\_\_\_\_-\_\_\_\_

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

Is the facility Medicare certified: \_\_\_\_YES \_\_\_\_NO If yes:

CERTIFICATION NO (ORIGINAL): \_\_\_\_\_ CATEGORY: \_\_\_\_\_

ORIGINAL CERT. DATE: \_\_/\_\_/\_\_ CURRENT CERT. 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 Interns/Residents at most recent Fiscal Year end \_\_\_\_\_

Residential Treatment Centers (RTC), Substance Use Disorder Rehabilitation Facilities (SUDRF) and Psychiatric Partial Hospitalization Programs (PHP) must be certified by the National Quality Monitoring Contract (NQMC-Maximus). Their phone number is: 1-608-308-7160

NQMC- Maximus  
1600 E Northern Ave  
Ste. 100  
Phoenix AZ 85020

**HUMANA MILITARY**  
HEALTHCARE SERVICES



*A Legacy of Service*



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HEALTH PROGRAM BENEFIT AGREEMENT

In order to receive payment under TRICARE Management Activity (TMA),
\_\_\_\_\_, dba \_\_\_\_\_
the provider of services agrees:

(A) To accept as payment for inpatient services provided to eligible beneficiaries, the TRICARE determined allowable amount. This amount will be determined in accordance with the requirements of Title 32 of the Code of Federal Regulations Part 199 (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 1973 as amended, and upon acceptance by the Director, TMA, or his 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 TMA BY:

NAME

NAME

TITLE DATE

TITLE DATE





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An assistant surgeon is a physician, dentist or podiatrist acting within the scope of their license who actively assists the operating surgeon in the performance of a covered surgical service. Physician assistants are also recognized as assistant surgeons under TRICARE. 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 BELOW

HAS NO INTERNAL STAFF AVAILABLE AT ANY TIME TO PERFORM THE SERVICES OF AN ASSISTANT SURGEON.

\_\_\_\_\_  
SIGNATURE                      TITLE                      DATE

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





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Skilled Nursing Facility
(SNF) Participation Agreement

Agreement between TRICARE and \_\_\_\_\_(Provider)

doing Business as (DBA)\_\_\_\_\_

TRICARE Provider ID/Number\_\_\_\_\_Medicare Provider No.\_\_\_\_\_

NPI#\_\_\_\_\_

(To be completed by TRICARE Contractor) ~~~~~(To be completed by SNF)

In order to receive payment under 32 Code of Federal Regulations (CFR) Part
199, \_\_\_\_\_DBA

\_\_\_\_\_ as the Provider of skilled nursing services, agrees to
conform to the provisions of 32 CFR 199 and applicable provisions in TRICARE Manuals and applicable Medicare
provisions in 42 CFR.

This Agreement, upon submission by the Provider of skilled nursing services 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 TRICARE, shall be binding on the Provider of skilled nursing services and TRICARE.

The Provider of skilled nursing services certifies that:

~~~~a. The Provider is licensed by the State having jurisdiction for the
~~~~~Provider's area.

~~~~b. The Provider is Medicare (or Medicaid) certified and will continue to
~~~~~maintain Medicare certification. If at any time the provider is
~~~~~decertified by Medicare (or Medicaid), the provider agrees to notify the
~~~~~TRICARE contractor within 72 hours. Loss of Medicare (or Medicaid)
~~~~~certification will nullify this agreement. Note: For pediatric SNFs,
~~~~~Medicaid certification will be acceptable in lieu of Medicare
~~~~~certification.

~~~~c. The Provider will not discriminate against the TRICARE beneficiary in
~~~~~their admission practices or in delivery of medically necessary services
~~~~~due to the level of payment.

~~~~d. The Provider will use the same certification forms for TRICARE patients
~~~~~as are used and required for Medicare (or Medicaid) patients.

~~~~e. The Provider will participate on all TRICARE SNF claims and will accept
~~~~~TRICARE payment as the full payment and not balance bill the TRICARE
~~~~~beneficiaries. The Provider will collect the applicable cost-share
~~~~~amounts from the TRICARE beneficiaries.





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In the event of a transfer of ownership, this Agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ACCEPTED FOR THE PROVIDER OF SKILLED NURSING SERVICES BY:

NAME (SIGNATURE)

\_\_\_\_\_

TITLE-----DATE-----

\_\_\_\_\_

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SKILLED NURSING SERVICES BY:

NAME (SIGNATURE)

\_\_\_\_\_

TITLE-----DATE-----

\_\_\_\_\_

PKEY: 123456789





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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."





## 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 |
|--|
|--|

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 |  |
|--------------------------------------|--|

| 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.**

