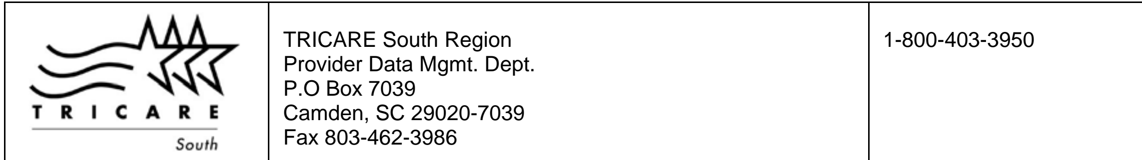

TRICARE South Region
Provider Data Mgmt. Dept.
P.O Box 7039
Camden, SC 29020-7039
Fax 803-462-3986
1-800-403-3950

TRICARE PROVIDER FILE APPLICATION

CORPORATION NAME: ____

FEDERAL TAX NUMBER: _____________________NPI#_________________________

Office Location (Street Address): Mailing Address (If different):

_____________________________________ _____________________________

_____________________________________ _____________________________

Office Telephone Number:(___)____-_____Billing Telephone Number: (___)____-_____

PLEASE CHECK APPROPRIATE BOX:

I certify that I have met the following requirements to be reimbursed as a(n):

____ AMBULANCE (Complete Section A)

____ INDEPENDENT CLINICAL LABORATORY (Complete Section B)

____ INDEPENDENT PHYSIOLOGICAL LABORATORY (Complete Section C)

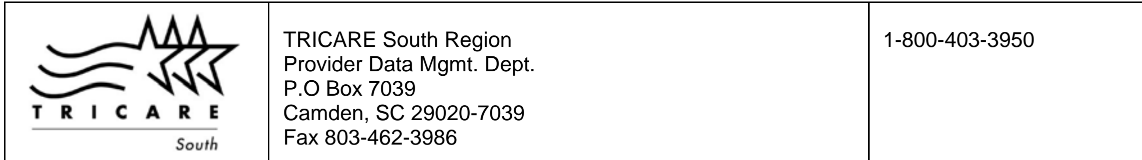
____ PORTABLE X-RAY SUPPLIER (Complete Section D)

____ PHARMACY (Complete Section E)

____ DURABLE MEDICAL EQUIPMENT SUPPLIER (Complete Section E)

____ PARENTERAL AND ENTERAL SUPPLIES (Complete Section E)

____ IMMUNOSUPPRESSANT DRUGS (Complete Section E)



TRICARE South Region
Provider Data Mgmt. Dept.
P.O Box 7039
Camden, SC 29020-7039
Fax 803-462-3986

1-800-403-3950

SECTION A

License No: _____________________ Issuing State: ____________
Date: ____/____/____

Is license _______ TEMPORARY ______ PERMANENT

ATTACH A COPY OF YOUR LICENSE AND/OR CERTIFICATION.

If your state does not offer licensure you must include a signed and dated statement on letterhead by an official of the organization operating the ambulance service stating that (1) there is no license requirement for the operation of an ambulance service within the geographic area served by the ambulance service, or (2) that the organization is exempt from a license requirement for the operation of an ambulance service with an explanation of the legal basis for exemption.

PLEASE CHECK APPROPRIATE BOXES: I certify that the above-named ambulance company meets the following requirements:

___ Each of the company's ambulance vehicles are specially designed and equipped for emergency transportation of the sick and injured, AND

___ The minimum ambulance crew consists of at least two members, one of whom must have a minimum training at least equivalent to that provided by the Red Cross first aid course.

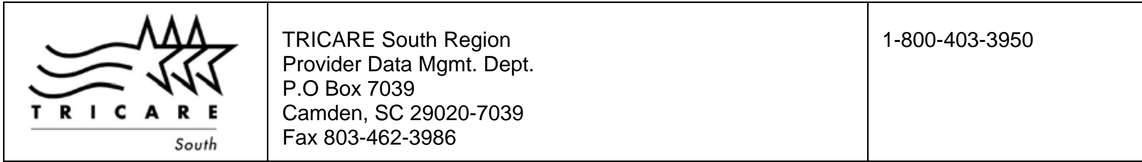
___ The ambulance company agrees to notify PGBA, LLC of any change in company ownership and/or operation which results in:

1. The use of vehicles as ambulances which are specially designed and equipped for emergency transportation of the sick and injured, OR
2. When the minimum first aid requirement for crew members is less than that of the advanced Red Cross first aid course equivalent, OR
3. When the political jurisdiction in which the ambulance company is based requires a license to operate an ambulance service within their jurisdiction.

______________________	______________________	______________
SIGNATURE	TITLE	DATE

Please Return To:

TRICARE
Provider Data Management
PO Box 7039
Camden, SC 29020-7039


TRICARE South Region
Provider Data Mgmt. Dept.
P.O Box 7039
Camden, SC 29020-7039
Fax 803-462-3986

1-800-403-3950

PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

STATE OF ______________________________ COUNTY OF __________________

Know all persons 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 TRICARE. My signature by my said attorney-in-fact includes my agreement to abide by the TRICARE payment system concept and the remainder of the certification appearing on all TRICARE 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 where of I have here unto set my hand this _________________ day of ________20____.

____
SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS _______________ DAY OF _______20_____

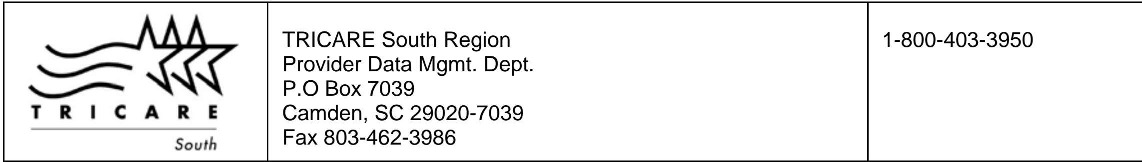
____
NOTARY PUBLIC IN AND FOR

COUNTY OF ___________________________ STATE OF ________________________

(SEAL) MY 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 facsimiles signature or 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.



PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

STATE OF ______________________________

COUNTY OF ____________________________

____ being first duly sworn, deposes and says: I hereby authorize the TRICARE Management Activity 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 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.

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. PBGA 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 (*Please Print*)	Date
Signature (*I am authorized to endorse this enrollment on behalf of my company.*)	Phone

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

If your corporate headquarters will be receiving ERA's/EFT's for satellite offices, please list them below.

TRICARE Provider Number (with suffix)	**National Provider Identifier (NPI #)**	**Business Name and Address**

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