



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

Toll-Free: 1-800-403-3950

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 Intern/Residents at most recent Fiscal Year end

_____ Residential Treatment Facilities (RTC), Substance Use Disorder Rehabilitation Facilities (SUDRF) and Psychiatric Partial Hospitalization Programs (PHP) must be certified by the Colorado Foundation for Medical Care. Their address is:

Colorado Foundation for Medical Care
Attention: GERALYN A. KEANE, R.N. Programs Manager, TSO Contract
PO Box 17300
Denver, CO 80217-0300



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HEALTH PROGRAM BENEFIT AGREEMENT

In order to receive payment under TRICARE Management Activity (TMA),
 _____ dba _____ as 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 DoD 6010.8-R as published in the FEDERAL REGISTER on September 1, 1987.

(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 DoD 6010.8-R 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.

(B)

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





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Dear Potential TRICARE Hospice Provider:

The FI/Contractor is responsible for calculation of the cap amount and inpatient limitation for each TRICARE approved hospice program within its jurisdictional area. Therefore, if you chose to become a participating TRICARE approved hospice provider, certain data will be required by PGBA, LLC within 30 days of the end of each hospice cap year. The hospice cap year runs from September 28 of the previous cap year through September 27 of the current year.

For your convenience, we have enclosed a copy of the reporting form which will be used by hospice providers to supply the necessary information to PGBA, LLC.



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**PARTICIPATION AGREEMENT FOR
HOSPICE PROGRAM SERVICES
FOR TRICARE BENEFICIARIES**

CORPORATE NAME: _____

DBA (if different from above): _____

LOCATION: _____

MAILING ADDRESS:
(if different from location) _____

TELEPHONE: _____

PROVIDER EIN NUMBER: _____

NPI NUMBER _____



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ARTICLE 1 RECITALS

1.1 Identification of Parties

This Participation Agreement is between the United States of America through the Department of Defense, TRICARE Management Activity (hereinafter TMA), a field activity of the Office of Secretary of Defense, the administering activity for TRICARE/Civilian Health and Medical Program of Uniformed Services Management Activity (hereinafter TMA) and _____, doing business as _____ (hereinafter designated the hospice program).

1.2 Authority for Hospice Care

The implementing regulations for TRICARE, 32 Code of Federal Regulations Part 199, provides for TRICARE cost-sharing of hospice care under certain conditions.

1.3 Intent of Participation Agreement

It is the intent of this participation agreement to recognize the undersigned hospice program as a TRICARE-authorized provider of hospice care, subject to terms and conditions of this agreement, and applicable federal law and regulation.

1.4 Billing Number

The number used for billing of all hospice care is the hospice program's employer identification number (EIN). This number must be used until the provider is officially notified by TMA of a change. The hospice program's billing number is shown on the face sheet of this agreement. It is the only billing number that will be accepted by TMA claims processors after the effective date of this hospice program under TRICARE.

ARTICLE 2 PERFORMANCE PROVISIONS

2.1 General Agreement

The hospice program agrees to render palliative hospice care to eligible TRICARE beneficiaries as required by this participation agreement and the TRICARE regulation (32 CFR 199). The terms and conditions of 32 CFR 199 applicable to the participation or treatment of TRICARE beneficiaries by hospice programs are incorporated herein by reference.

2.2 Coverage/Benefits





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(a) The hospice program agrees to provide the care and services set forth in 32 CFR 199.4(e)(19)(i).

(b) The hospice program further agrees to provide for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the hospice program, except that the agency must:

- (1) Routinely supply a substantial amount of core-services (i.e., nursing services; physician services; medical social services; and counseling) services for the TRICARE beneficiary and his or her family. (32 CFR 199.4(e)(19)(ii))
- (2) Maintain professional management responsibility of non-core services (i.e., home health aide services, medical appliances and supplies, physical therapy, occupational therapy, speech language pathology and short-term inpatient care) which are not directly furnished to the patient, regardless of the location or facility in which the services are rendered. (32 CFR 199.4(e)(19)(iii))
- (3) Make nursing services, physician services, and drugs and biologicals routinely available on a 24-hour basis. All other covered services must be available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for palliation and management of the terminal illness and related condition. (32 CFR 199.4(e)(19)(iv))
- (4) Provide assurances that the aggregate number of days of inpatient care provided in any 12-month period does not exceed 20 percent of the aggregate number days of hospice care during the same period.
- (5) Have an interdisciplinary group (i.e., one physician; one registered nurse; one social worker; and one pastoral or other counselor) who provides those services set forth in 32 CFR 199.4(e)(19)(i) and establishes the policies governing the provision of such services/care.
- (6) Maintain central clinical records on all patients.

2.3 Conditions for Coverage

Under the terms of this agreement, the hospice program shall:





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(a) Assure that there is written certification in the medical records that the TRICARE beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

(1) For the initial 90-day period, the hospice must obtain written certification statements from the individual's attending physician (if the individual has an attending physician) and the medical director of the hospice or the physician member of the hospice interdisciplinary team no later than two days after the period begins. If written certifications cannot be obtained within two calendar days, then oral certification must be obtained within two calendar days, followed by written certification no later than eight calendar days after hospice care is initiated.

(2) Recertification is required for any subsequent periods (for periods two, three and four) of hospice care for which the beneficiary is eligible. The hospice medical director or staff physician will be responsible for recertifying TRICARE beneficiaries for subsequent election periods. A written certification must always be in the medical records not later than two days after hospice care is initiated.

(b) Design and print its own election statements to include the following information:

(1) identification of the particular hospice that will provide care to the individual;

(2) individual's or representative's acknowledgement that he or she has been given a full understanding of hospice care;

(3) individual's or representative's acknowledgement that he or she understands that certain TRICARE services are waived by the election;

(4) effective date of election; and

(5) signature of the individual or representative.

(c) Assure that an election statement is in the clinical records prior to signing the Notice of Admission. This includes the admission date, which must be the same date as the effective date of the hospice election. The hospice program must notify the contractor of the initiation, change or revocation of any election.

(d) Establish a written plan of care on the same day that a member of the basic interdisciplinary group assesses the patient's needs. The attending physician and medical director or physician designee must review the initial plan of care and provide their input within two calendar days following the day of the assessment.

2.4 Certification Requirements





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The hospice program certifies and attaches hereto documentation that:

- (a) it is Medicare approved and meets all Medicare conditions of participation (42 CFR 418); and
- (b) is licensed pursuant to any applicable state or local law.

2.5 Quality of Care

(a) The hospice program shall assure that any and all eligible beneficiaries receive hospice services that are reasonable and necessary for the palliation or management of a terminal illness and meet the conditions for coverage as established in Article 2.3 above.

(b) The hospice program shall provide hospice services in the same manner to TRICARE beneficiaries as it provides to all patients to whom it renders service.

(c) The hospice shall not discriminate against TRICARE beneficiaries in any manner, including admission practices or provisions of special or limited treatment.

2.6 Billing Form

(a) The hospice program shall use the UB-92 billing form (or subsequent editions.) Hospice care shall be identified in item 4 of this form.

(b) The UB-92 billing form (or subsequent editions) will also use as an admission notice. This notice will be used to notify the contractor of the initiation, change or revocation of an election.

2.7 Compliance with TMA Medical Review Activities

(a) Submit all medical records and documentation to the contractor and, where applicable, to the Peer Review Organization within 30 days of the date of their request.

(b) Failure to submit the requested information will result in denial of the claim.

2.8 Staff Qualifications

The hospice shall comply with requirements for professional staff qualifications as established in 32 CFR 199.4 and 32 CFR 199.6.

Article 3 PAYMENT PROVISIONS

3.1 The hospice program agrees to accept reimbursement at one of four predetermined national TRICARE rates (32 CFR 199.14(9)) adjusted for regional wage





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differences using appropriate Medicare wage indices as payment in full, except for physician-directed services and applicable cost-shares. The hospice will be reimbursed for an amount applicable to the type and intensity of the services furnished (i.e., routine home care, continuous home care, inpatient respite care and general inpatient care) to the TRICARE beneficiary on a particular day.

(a) One rate will be paid for each level of care, except for continuous home care where reimbursement is based on the number of hours of continuous care furnished on a particular day. The following requirements must be met in order to receive reimbursement for continuous home care:

(1) More than half of the period of continuous care must be provided by either a registered or licensed practical nurse.

(2) A minimum of 8 hours must be provided during a 24-hour day which begins and ends at midnight. If less than 8 hours of care are provided within a 24-hour period, the care will be paid at the lower routine home care rate.

(b) Payment for inpatient respite care may be for a maximum of 5 days at a time, including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

(c) The hospice program agrees to submit all claims as a participating provider. TMA agrees to make payment of the TRICARE-determined rate directly to the hospice program for any care authorized under this agreement.

(d) There may be a reclassification of care from one rate category to another as a result of medical review of hospice claims. For example, if continuous home care is provided to a TRICARE beneficiary whose condition did not require the level of care described in 32 CFR 199.14 (or did not receive it), payment is made for the services at the routine home care rate.

3.2 Physician reimbursement is dependent on the physician's relationship with both the beneficiary and the hospice program.

(a) Physicians employed by, or contracted, with, the hospice

(1) Administrative and supervisory activities (i.e., establishment, review and updating of plans of care, supervising care and services, and establishing governing policies) are included in the adjusted national payment rate.

(2) Direct patient care services are subject to the appropriate TRICARE allowable charge methodology and are counted toward cap limitation.

(b) Independent attending physician. Patient care services rendered by an independent attending physician (a physician who is not considered employed by, or



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under contract with, the hospice) are not part of the hospice benefit and may be billed in his/her own right.

(1) Services are subject to the appropriate allowable charge methodology but not counted toward the cap limitation.

(2) Services must be coordinated with any direct care services provided by hospice physicians.

(3) The hospice must notify the contractor of the name of the physician whenever the attending physician is not a hospice employee.

(c) No payments are allowed for physician services furnished voluntarily (both physicians employed by, and under contract with, the hospice and independent attending physicians). Physicians may not discriminate against TRICARE beneficiaries; e.g., designate all services rendered to non-TRICARE patients as volunteer and at the same time bill for TRICARE patients.

3.3 The hospice program agrees to the cap and inpatient limitations as prescribed in 32 CFR 199.14(g)(3).

(a) The hospice program further agrees to furnish such information as the contractor deems necessary for calculation and application of the cap amount and inpatient limitations within 30 days after the end of the cap period.

(b) Payments in excess of the cap and/or inpatient limitations must be refunded by the hospice.

(c) A hospice may request and obtain a contractor's review of calculation and application of its cap amount and inpatient limitation if the amount in controversy meets the administrative dollar level established in 32 CFR 199.14(g)(3). These calculations are not subject to the appeal procedures set forth in 32 CFR 199.10.

3.4 The hospice program agrees to hold eligible TRICARE beneficiaries harmless (not to charge the beneficiary) for the following services:

(a) those for which the provider is entitled to payment from TRICARE;

(b) those for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements (e.g., election notification, care plan and submission of requested records within 30 days);

(c) those which are not necessary for the palliation or management of the terminal illness; NOTE: If the patient is informed that the services are not covered under the TRICARE hospice benefit and continues to insist that it be performed, he or she will be liable for payment. The above item only applies to those services and supplies prescribed by the hospice.



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(d) those for which a beneficiary would be entitled to payment, but for a reduction or denial in payment as a result of quality review;

(e) those rendered during a period in which the hospice was not in compliance with one or more conditions for coverage.

3.5 TRICARE as Secondary Payor

(a) The hospice program is subject to the provisions of 10 USC Section 1079(j)(1). The hospice program must submit claims first to all other insurance plans and/or medical service or health plans under which the beneficiary has coverage before submitting a claim to TRICARE.

(b) Failure to collect first from primary health insurers and/or sponsoring agencies is a violation of this agreement, may result in denial or reduction of payment, and may result in a false claim against the United States. It may also result in termination by TMA of this agreement pursuant to Article 5.

3.6 Collection of Cost-Share

(a) The hospice program agrees to collect from the TRICARE beneficiary only those amounts applicable to the patients cost-share as defined in 32 CFR 199.14(g)(8).

(b) The collection of cost-shares by individual hospice programs is optional under TRICARE. The waiver of cost-sharing will not be considered fraudulent billing under 32 CFR 199.9.

3.7 Beneficiary's Rights

If the hospice program fails to abide by the terms of this participation agreement and TMA or its designee either denies the claim or claims and/or terminates the agreement as a result, the hospice agrees to forego its rights, if any, to pursue the amounts not paid by TRICARE from the beneficiary or the beneficiary's family.

ARTICLE 4 RECORDS AND AUDIT PROVISIONS

4.1 On-Site and Off-Site Reviews/Audits

The hospice program grants the Executive Director, TMA or designee the right to conduct quality assurance audits or accounting (record) audits with full access to patients and records. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. The right to audit/review includes, but is not limited to:



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(a) Examination of fiscal and all other records of the hospice program which would confirm compliance with this agreement and designation as an authorized TRICARE hospice provider.

(b) Audits of hospice program records including clinical, financial, and census records to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided TRICARE beneficiaries. TMA or a designee shall have full access to records of both TRICARE and non-TRICARE patients.

(c) Examination of reports of evaluations and inspections conducted by federal, state, local government and private agencies and organizations

4.2 Right to Unannounced Inspection of Records

(a) TMA or its designee, shall have the authority to visit and inspect the hospice program at all reasonable times on an unannounced basis.

(b) The hospice program's records shall be available and open for review by TMA during normal working hours (8am to 5pm, Monday through Friday) on an unannounced basis.

4.3 Certified Cost Reports

Upon request, the hospice program shall furnish TMA or a designee audited cost reports certified by an independent auditing agency.

4.4 Records Requested by TMA

Upon request, the hospice program shall furnish TMA or a designee such records, including medical records and patient census records, that would allow TMA or a designee to determine the quality and cost effectiveness of care rendered.

4.5 Failure to Comply

Failure to allow audits/reviews and/or to provide records constitutes a material breach of this agreement. It may result in denial or reduction of payment, termination of this agreement pursuant to Article 6, and any other appropriate action by TMA.

ARTICLE 5 GENERAL ACCOUNTING OFFICE

5.1 Right to Conduct Audit

The hospice program grants the United States General Accounting Office the right to conduct audits.



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ARTICLE 6 TERMINATION AND AMENDMENT

6.1 Termination of Agreement by TMA

(a) The Executive Director, TMA, or designee, may terminate this agreement upon 30 days written notice, for cause, if the hospice program is not complying substantially with the provisions of this agreement or with applicable provisions set forth in 32 CFR 199. Causes for termination include violation of patient charging and cost reporting procedures, refusal to provide required program information or willfully providing false information, failing to meet the Conditions of Participation, and administrative remedies involving fraud, abuse, or conflict of interest as set forth in 32 CFR 199.9. Such written notice of termination shall be an initial determination for purposes of the appeal procedures set forth in 32 CFR 199.10. NOTE: The notice provisions in this article do not limit TMA's authority to suspend claims processing or seek recoupment of claims previously paid.

(b) After termination of the agreement, the hospice program may not file another agreement to participate unless TRICARE finds that the reason for termination of the prior agreement has been removed and that there is reasonable assurance that it will not recur.

6.2 Termination of Agreement by the Hospice Program

The hospice program may terminate this agreement by giving the Executive Director, TMA, or designee, written notice of such intent to terminate at least 6 months in advance of the effective date of termination. If the hospice program permanently or temporarily ceases to furnish services to the community, the agreement terminates effective with the date the program goes out of business.

6.3 Amendment by TMA

(a) The Executive Director, TMA, or designee, may amend the terms of this participation agreement by giving 120 days notice in writing of the proposed amendment(s) EXCEPT when necessary to amend this agreement from time to time to incorporate changes to the TRICARE regulation. When changes or modifications to this agreement result from changes to the TRICARE regulation through rulemaking procedures, the Executive Director, TMA, or designee, is not required to give 120 days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective or the date this agreement is amended, whichever date is earlier.

(b) The hospice program, not wishing to accept the proposed amendment(s), including any amendment resulting from changes to the TRICARE regulation accomplished through rulemaking procedures, may terminate its participation as provided in this Article. However, if the hospice program's notice of intent to terminate its



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participation is not given at least 6 months prior to the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into this agreement for services furnished by the hospice program between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 10 NONDISCRIMINATION

10.1 Nondiscrimination

The hospice program agrees to comply with provisions of Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112; as amended) regarding nondiscrimination on the basis of handicap, Title VI of the Civil Rights Act of 1964 (Public Law 88-352), and with the Americans With Disabilities Act of 1990 (Public Law 101-336), as well as all regulations implementing these Acts.

ARTICLE 11 ORDER OF PRECEDENCE

11.1 Order of Precedence

If there is any conflict between this agreement and any Federal statute or Federal Regulation, including the TRICARE/CIAMPUS regulation, 32 CFR Part 199 and Medicare Conditions of Participation (42 CFR 418), the statute or regulation controls.

ARTICLE 12 DURATION

12.1 Duration

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until such time as there is a voluntary or involuntary termination.

ARTICLE 13 EFFECTIVE DATE

13.1 Date Signed

(a) This participation agreement will be effective on the date signed by the Executive Director, TMA, or designee.

(b) This agreement must be signed by the President or Chief Executive Officer of the corporation that owns the hospice program and must be accompanied by a resolution of the hospice program's Board of Director authorizing the signature.



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ARTICLE 14 AUTHORIZED PROVIDER

14.1 Date Recognized

On the effective date of the agreement, TMA recognizes the hospice program as an authorized provider for purposes of providing hospice care to TRICARE eligible beneficiaries.

Hospice Program

By: _____
Signature

Type Name & Title

Corporate Name

Executed on _____, 20____

TMA

By: _____
Signature

Type Name & Title

Executed on _____, 20____



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HOSPICE REPORTING FORM

CAP PERIOD ENDED - October 31, 20_____

Hospice: _____

Provider Number: _____

1) Number of TRICARE beneficiaries electing hospice care during the period from 9/28/____ to 9/27/____. _____

2) Total payment received and receivable for the cap period from 11/1/____ through 10/31/____ for services furnished to TRICARE beneficiaries during the cap period, including employed physician's services not of an administrative and/or general supervisory nature. _____

3) Total reimbursement received and receivable for general inpatient respite care furnished to TRICARE beneficiaries for the period from 11/1/____ through 10/31/____. _____

4) Aggregate number of TRICARE inpatient days for both general inpatient care and inpatient respite care for the period from 11/1/____ through 10/31/____.

4a. Aggregate number of TRICARE routine days for the period from 11/1/ through 10/31/____. _____

4b. Aggregate number of TRICARE continuous home care hours for the period from 11/1/____ through 10/31/____. _____

5) Aggregate total number of days of hospice care provided to all TRICARE beneficiaries for the period from 11/1/____ through 10/31/____. _____

SIGNATURE

DATE

TITLE



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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
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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.

