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):

____

____

Telephone No: ______________________

Fax Number: ________________________

Mailing Address (If different):

____

____

Telephone No: ____________________

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. ________________	______________	________________	______________	_____________
2. ________________	______________	________________	______________	_____________
3. ________________	______________	________________	______________	_____________
4. ________________	______________	________________	______________	_____________
5. ________________	______________	________________	______________	_____________
6. ________________	______________	________________	______________	_____________
7. ________________	______________	________________	______________	_____________
8. ________________	______________	________________	______________	_____________

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.

SECTION B

CLINICAL LICENSED SOCIAL WORKER

Each Clinical Licensed Social Worker 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 in Social Work.

   Date Graduated: _____/_____/_____ Degree Type: ___________________

   Name of University: ____

3. Have had a minimum of two years or three thousand hours of post-Master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the contractor.
   _____ 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.

____________________________________ FACSIMILE OR STAMP SIGNATURE
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 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)

Compete 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
____City
______________________ State _________ Zip Code ____________

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
____City
______________________ State _________ Zip Code ____________

Phone Number ____________________ Fax Number ____________________
E-mail Address ____

I hearby 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