



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 PROVIDER FILE APPLICATION
CLINIC OR GROUP PRACTICE
PROFESSIONAL ASSOCIATION, CORPORATION, PARTNERSHIP, CLINIC, ETC

GROUP NAME: _____ NPI# _____

FEDERAL TAX NUMBER: _____ TELEPHONE: (____) _____ - _____

Office Location (Street Address):

Billing Address (If different):

NOTE: If you use a billing agency, please designate telephone number for billing inquiries: _____

Date legal entity established ____/____/____

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, EACH PHYSICIAN MUST COMPLETE THE ATTACHED SIGNATURE AUTHORIZATION FORMS AND HAVE THEM NOTARIZED.

Do you use a Patient Account Number? ___ YES ___ NO

Do you currently file claims electronically to PGBA, LLC? ___ YES ___ NO If YES, Terminal Number _____

IMPORTANT: ALL GROUP MEMBERS MUST COMPLETE AN INDIVIDUAL APPLICATION AND A REASSIGNMENT OF BENEFITS FORM.

PLEASE complete one application for EACH location.



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ATTACH A PHOTOCOPY OF YOUR LICENSE OR CERTIFICATION

License No: _____ Issuing State: _____

Original License Date: _____

Current License Effective Dates: From _____ To _____

CONFLICT OF INTEREST STATEMENT

“Federal Law (5 U.S.C. 5536) prohibits medical personnel who are active duty members or civilian employees of government from receiving additional government compensation above their normal pay and allowance for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. Claims for TRICARE benefits will be denied where either a uniformed member or civilian employee of the uniformed services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selective basis.”

Signature of Applicant

Signature Date

“I, the undersigned provider, in submitting this application for certification as an authorized provider under the TRICARE program, do affirm and attest that the information which I have provided in response to and support of this application is true and correct. I understand that any misrepresentation of my credentials which bear upon my qualification for authorized TRICARE provider status may be subject to the Administrative Remedies for Fraud, Abuse and Conflict of Interest as defined in 32 CFR 199.9.”

Signature of Applicant

Signature Date

Please notify Provider Certification of any changes related to your provider file information (name, address, specialty, tax number, group affiliations, etc.).



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GROUP MEMBER LISTING

Please list all of the MEDICAL DOCTORS (MD'S) and OSTEOPATHS (DO'S) 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 AND NPI NUMBERS	LICENSE NUMBER	PRIMARY SPECIALTY	DATE MD/DO JOINED GRP
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1. _____ / _____
 (SSN / NPI)
 ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES: __/__/__ TO __/__/__

2. _____ / _____
 (SSN / NPI)
 ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES: __/__/__ TO __/__/__

3. _____ / _____
 (SSN / NPI)
 ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES: __/__/__ TO __/__/__

4. _____ / _____
 (SSN / NPI)
 ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES: __/__/__ TO __/__/__

5. _____ / _____
 (SSN / NPI)
 ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES: __/__/__ TO __/__/__

6. _____ / _____
 (SSN / NPI)
 ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES: __/__/__ TO __/__/__

7. _____ / _____
 (SSN / NPI)
 ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES: __/__/__ TO __/__/__

8. _____ / _____
 (SSN / NPI)
 ORIGINAL LICENSE DATE: __/__/__ CURRENT LICENSE DATES: __/__/__ TO __/__/__

PLEASE PHOTOCOPY THIS FORM IF YOU HAVE MORE THAN EIGHT PHYSICIANS IN YOUR GROUP.





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SECTION H

CERTIFIED NURSE ANESTHETISTS

Provider Name: _____ Specialty: _____

RN License Information: ATTACH A COPY OF LICENSE.

License No.: _____ Issuing State: _____

Original Issue Date: ____/____/____ Expiration Date: ____/____/____

ATTACH A PHOTOCOPY OF THE CARD ISSUED TO YOU by either the Council on Certification of Nurse Anesthetists or by the Council on Recertification of Nurse Anesthetists.

Certification No.: _____ Issuing State: _____

Original Certification Date: ____/____/____

Expiration Date: ____/____/____

Name of Preceptor(s) (Supervising Physician) for practice:

Highest degree level: _____

Institution: _____

I understand that continued privileges are contingent on continued certification by either the Council on Certification on Nurse Anesthetists or by the Council on Recertification.

Signature Date



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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 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 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.





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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 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.





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PHYSICIAN AUTHORIZATION FOR REASSIGNMENT OF BENEFITS TO CLINIC

TRICARE
PGBA, LLC

It is agreed that _____
(Name of Clinic, Group or Professional Association)

will bill for and receive any charges or fees for the services of

(Name of Provider)

(Office Address)

Signature-Authorized Individual for Clinic

Signature of Provider

Employer Identification Number

Social Security Number

NPI# for Employer Identification Number

NPI# for Social Security Number

Date

Date

Date individual joined group practice: _____

Please return to the address indicated at the top of this letter.

