



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

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 Management
P.O. Box 7039
Camden, SC 29020-7039
Fax 803-462-3986

Toll-Free: 1-800-403-3950

SECTION D

Is licensure required in your state? YES (Photocopy is attached)

NO (Licensure not Required)

Does the Portable X-Ray operate independently of a hospital, physician's office or rural health clinic? YES NO

Are diagnostic services performed by the Portable X-Ray ordered by a referring physician? YES NO

Are you approved for participation in the Medicare program? YES NO

ATTACH A PHOTOCOPY OF THE HEALTH AND HUMAN SERVICES LETTER WHICH STATES THE PORTABLE X-RAY MEETS ALL MEDICARE CERTIFICATION REQUIREMENTS:



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

Toll-Free: 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.





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

Toll-Free: 1-800-403-3950

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 TRICARE 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.

