



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

NAME: _____ SOCIAL SECURITY NO: _____

If you are a solo incorporate, EIN #: _____

NPI#: _____

Office Location (Street Address):

Billing Address (If different):

Office Phone No: (____)____-____

Billing Phone No: (____)____-____

If you file your taxes under a Federal Employer Identification Number because you belong to an incorporated group/professional association, you must ALSO complete a GROUP APPLICATION and the enclosed REASSIGNMENT OF BENEFITS FORM.

Are you a member of an established group practice or institution? _____ YES _____ NO

If YES, Practice Name: _____ Provider No: _____

Date you began filing with group number: ____/____/____ NPI# _____

Do you maintain a solo practice by yourself? _____ YES _____ NO

I will be signing my own claim forms: _____ YES _____ NO. If not, then the enclosed FACSIMILE SIGNATURE AUTHORIZATION FORM (S) MUST BE COMPLETED.

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

_____ PHYSICIAN ASSISTANT





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ATTACH A PHOTOCOPY OF YOUR LICENSE OR CERTIFICATION

License No: _____ UPIN: _____ NPI: _____

Original License Date: _____ Issuing State: _____

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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SECTION G

YOUR EMPLOYING PHYSICIAN MUST BE AN AUTHORIZED TRICARE PROVIDER AND A COMPLETED GROUP APPLICATION MUST BE ON FILE WITH PGBA, LLC.

Name of Employing Physician or Group: _____ EIN: _____

Telephone: (____) _____ Date you joined group: ____/____/____

YOU MUST ALSO COMPLETE A REASSIGNMENT OF BENEFITS FORM IN ORDER FOR THE PRACTICE TO DO YOUR BILLING.

IF STATE LICENSURE IS AVAILABLE IN YOUR STATE OF PRACTICE, IT IS REQUIRED EVEN IF THE STATE OFFERS LICENSURE ON A VOLUNTARY BASIS.

License No: _____ Issuing State: _____

Original License Date: _____ Current License Dates: From _____ To _____

ATTACH A PHOTOCOPY OF YOUR LICENSE.

I certify that I meet the applicable state requirements governing qualifications for physician assistants and at least one of the following:

_____ I am currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians, OR
 ATTACH COPY OF CERTIFICATION EFFECTIVE DATE: ____/____/____

_____ I have satisfactorily completed a program for preparing physician assistants that:

- A. Was at least one academic year in length; and
 - B. Consisted of supervised clinical practice and at least four months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and
 - C. Was accredited by the American Medical Association's Committee on Allied Health Education and Accrediation; OR
- ATTACH PROOF OF COMPLETION EFFECTIVE DATE: ____/____/____

_____ I have satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of paragraph 2 of this section and had been assisting primary care physicians for a minimum of twelve months during the 18-month period immediately preceding January 1, 1987.
 ATTACH COPY OF CERTIFICATION EFFECTIVE 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.

