TRICARE CORPORATE SERVICES PROVIDER APPLICATION

FACILITY NAME:_____

CORPORATE/FOUNDATION NAME IF DIFFERENT:_____

FEDERAL TAX ID NO:_____ NPI#_____

Telephone number: _____ Facsimile number: _____

PHYSICAL LOCATION (Street Address): MAILING ADDRESS (If different):

_____ _____

_____ _____

_____ _____

Date legal entity established _____

Are you a MEDICARE provider? ☐ Yes ☐ No

If yes: MEDICARE Certification no:_____

MEDICARE CATEGORY:_____

MEDICARE ACCEPTANCE DATE:_____

Are you JCAHO accredited? ☐ Yes ☐ No If yes: JCAHO classification:_____

Original classification date:_____

Current JCAHO classification dates FROM:_____ TO:_____

STATE License classification:_____

Dates of state licensure FROM:_____ TO:_____

Are you certified by a national board? ☐ Yes ☐ No

If yes: Name of board:_____ Effective date of certification:_____

NOTE: You must attach a copy of your Medicare, JCAHO, State, and National Board Certificates/Licenses.

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

Revised: 1/20/2015

TRICARE CORPORATE SERVICE PROVIDER APPLICATION

PLEASE CHECK APPROPRIATE BOX:

☐ RADIATION THERAPY

☐ CARDIAC CATHETERIZATION CLINIC

☐ FREESTANDING SLEEP DISORDER DIAGNOSTIC CENTER

☐ INDEPENDENT PHYSIOLOGICAL LABORATORIES

☐ FREESTANDING KIDNEY DIALYSIS CENTER

☐ FREESTANDING MRI CENTERS

☐ COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

☐ HOME HEALTH AGENCY

☐ FREESTANDING BONE MARROW TRANSPLANT CENTER

☐ HOME INFUSION

☐ DIABETIC OUTPUT SELF MANAGEMENT EDUCATION PROGRAM
(Attach copy of Certification of Recognition from the American Diabetes Association)

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Application for TRICARE-Provider Status

CORPORATE SERVICES PROVIDER

The public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0020), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

DIRECTIONS:

To apply for certification as a TRICARE-authorized provider, read and complete all sections of this application and return it with all attachments to the following address:

PGBA, LLC.
Attn: TRICARE Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756
OR
Fax 1-888-279-3540

For inquiries, please call the toll-free 1-877-TRICARE.

Provider name:_____
NOTE: All Applications must be signed by the chief executive officer and dated.

The above-named provider has applied to become a TRICARE-authorized provider. The signee certifies that the information in this application and attachments is true and accurately represents and depicts the above-named provider.

_____ _____
Chief Executive Officer Date

PGBA, LLC
Provider Management
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Revised: 1/20/2015

PARTICIPATION AGREEMENT

In order to receive payment under TRICARE,
_____

dba_____, as the provider of services agrees:

1. Not to charge a beneficiary for the following:

   a. Services for which the provider is entitled to payment from TRICARE;

   b. Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements;

   c. Services not medically necessary and appropriate for the clinical management of the presenting illness, injury, disorder or maternity;

   d. Services for which a beneficiary would be entitled to payment but for a reduction or denial in payment as a result of quality review; and

   e. Services rendered during a period in which the provider was not in compliance with one or more conditions of authorization:

2. To comply with applicable provisions of 32 CFR 199 and related TRICARE policy;

3. To accept the TRICARE determined allowable payment combined with the cost-share, deductible, and other health insurance a amounts payable by, or on behalf of, the beneficiary, as full payment for TRICARE allowed services;

4. To collect from the TRICARE beneficiary those amounts that the beneficiary has a liability to pay for the TRICARE deductible and cost-share/co-payment;

5. To permit access by the Executive Director, DHA, or designee, to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state or private agencies or organizations;

6. To provide to the Executive Director, DHA, or designee (e.g., Managed Care Support Contractor), prompt written notification of the provider's employment of an individual who, at any time during the twelve months preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly, or indirectly, for decisions regarding Department of Defense payments to the provider;

7. To cooperate fully with a designated utilization and clinical quality management organization which has a contract with the Department of Defense for the geographic area in which the provider renders services;

8. Comply with all applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/ co-payment may be expected;

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Revised: 1/20/2015

9. To maintain clinical and other records related to individuals for whom TRICARE payment was made for services rendered by the provider, or otherwise under arrangement, for a period of 60 months from the date of service;

10. To maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, the methods, modalities or means of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment;

11. To refer TRICARE beneficiaries only to providers with which the referring provider does not have an economic interest, as defined in 32 CFR 199.2;

12. To limit services furnished under arrangement to those for which receipt of payment by the TRICARE authorized provider discharges the payment liability of the beneficiary; and

13. Meet such other requirements as the Secretary of Defense may find necessary in the interest of health and safety of the individuals who are provided care and services.

Defense Health Agency (DHA) agrees to:

Pay the above-named provider the full allowable amount less any applicable double-coverage, cost-share/co-payment, and deductible amounts.

This agreement shall be binding on the provider and DHA upon acceptance by the Executive Director, DHA, or designee.

This agreement shall be effective until terminated by either party. The effective date shall be the date the agreement is signed by DHA.

This agreement may be terminated by either party by giving the other party written notice of termination. The provider shall also provide written notice to the public. Such notice of termination is to be received by the other party no later than 45 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 DHA BY:	
_____		_____	
Name		Name	
_____		_____	
Title	Date	Title	Date

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Revised: 1/20/2015

Non-Network UB-04 "Signature on File" for TRICARE Claims Form

Please complete the following information and return by fax to 1-888-250-4355

This form serves the purpose of the signature requirements indicated in the TRICARE Operations Manual (Chapter 8, Section 4, Paragraph 10.0.)

> "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 signature on file requirements do not apply to the claim. If a non-network participating claim does not contain an acceptable signature, return the claim."

I, _____ hereby authorize PGBA, LLC / Health Net
(print/type name here)

Federal Services in the state of South Carolina to accept my signature shown below as my true signature for all claim submissions for the facility indicated below.

Facility Name: _____

Facility Tax Identification Number: _____

Facility Physical Address:_____

Facility Phone Number:_____

Signature of Authorized Representative: _____

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Fax 1-888-279-3540

Revised: 1/20/2015

PGBA
A CELERIAN GROUP COMPANY

PGBA, LLC
TRICARE North EFT
PO Box 870154
Surfside Beach, SC 29587-9754
FAX 1-888-536-2324

Electronic Funds Transfer (EFT) Authorization Agreement

Please complete all fields on pages 1 and 2 of this form. Form Completion Guidelines and Terms and Conditions can be found on pages 2 and 3. Mail or fax the completed form along with required documentation to the address or fax number noted above. Please retain a copy of the completed EFT Authorization Agreement for your records.

Provider Information				
Provider Name:				
Provider Address:	Street:	City:	State:	Zip Code/Postal Code:

Provider Identifiers Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):	
National Provider Identifier (NPI) - *required when provider has been enumerated with an NPI:*	

☐	NOTE: Checking this box indicates payment for all locations of the above TIN to be transmitted to the Financial Institution Transit/Routing and Account number indicated on this EFT Authorization Agreement. Otherwise, if only specific locations are to be included, list them below. Attach additional sheets if necessary.

TRICARE Provider Number (with suffix):	National Provider Identifier (NPI):	Business Name and Address:

Provider Contact Information			
Provider Contact Name:		Telephone Number:	
Email Address:		Fax Number:	

Financial Institution Information				
Financial Institution Name:				
Financial Institution Routing Number:				
Type of Account at Financial Institution (check one):	Savings ☐		Checking ☐	
Provider's Account Number with Financial Institution:				
Account Number Linkage to provider Identifier (Must match ERA Preference) Check one:	Provider Tax Identification Number (TIN) ☐		National Provider Identification Number (NPI) ☐	

Note: If enrolled for 835 Electronic Remittance Advice (ERA), the provider must contact their financial institution to arrange for the delivery of the CORE-required minimum CCD+ data elements needed for association of the payment and the 835 ERA.

For assistance, contact our EDI Help Desk
1-877-334-2524 (1-877-EDI-CLAIM)
www.myTRICARE.com by PGBA

TRICARE North EFT
PO Box 870154
Surfside Beach, SC 29587-9754
FAX 1-888-536-2324

Submission Information									
Reason for Submission:	New Enrollment			Change Enrollment			Cancel Enrollment		
Include with Enrollment Submission:	Voided Check			Bank Letter					
Written Signature of Person Submitting Enrollment:									
Printed name of Person Submitting Enrollment:									
Printed Title of Person Submitting Enrollment:									
Submission Date:				Request EFT Start/Change/Cancel Date:					

Form Completion Guidelines

- Please type or print legibly using blue or black ink.
- To help expedite the process, you may enroll online at www.myTRICARE.com. In order to enroll online, you must have a myTRICARE Secure account. If you are not a registered myTRICARE Secure account holder, please go to www.myTRICARE.com to register.
- Please allow up to 4 weeks for the enrollment process which includes pre-note verification.
- Online instructions for checking the status of EFT payments can be found at www.myTRICARE.com.
- Once enrolled, EFT payments that have not been received after 4 business days of receipt of the corresponding ERA, online, or paper remittance can be researched by calling TRICARE North Region Customer Service at 1-877-874-2273.
- If you have any questions regarding the information contained in the EFT Authorization Agreement, please contact the TRICARE North EDI Help Desk at 1-877-334-2524.
- Mail or fax the completed form along with required documentation to:

PGBA, LLC
TRICARE North EFT
PO Box 870154
Surfside Beach, SC 29587-9751

Fax: 1-888-536-2324

Provider Information	
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider.
Provider Address	Street - The number and street name where a person or organization can be found.
	City - City associated with provider address field.
	State/Province - ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country
	Zip Code/Postal Code - System of postal zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities
Provider Identifiers	
Provider Federal Tax Identification Number (TIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions

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Provider Contact Information	
Provider Contact Name	Name of a contact in provider office for handling EFT issues.
Telephone Number	Associated with contact person.
Email Address	An electronic mail address at which the health plan might contact the provider.
Fax Number	A number at which the provider can be sent facsimiles.
Financial Institution Information	
Financial Institution Name	Official name of the provider's financial institution.
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are deposited.
Type of Account at Financial Institution	The type of account the provider will used to receive EFT payments (e.g., Checking, Savings).
Provider Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited.
Account Number Linkage to Provider Identifier	Provider preference for grouping (bulking) claim payments - must match preference for V5010 X12 835 remittance advice. Must select one of the following: Provider's Tax Identification Number (TIN) or National Provider Identifier (NPI).
Submission Information	
Reason for Submission	New Enrollment, Change Enrollment, Cancel Enrollment
Include with Submission	Voided Check - A voided check is attached to provide confirmation of Identification/Account Numbers.
	Bank Letter - A letter on bank letterhead that formally certifies the account owners routing and account numbers.
Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.
Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrolment.
Submission Date	The date on which the enrollment is submitted.
Requested EFT Start/Change/Cancel Date	The date on which the requested action is to begin.

TERMS AND CONDITIONS FOR ELECTRONIC FUNDS TRANSFER

By completing and submitting this form, 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 Agreement 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. PBGA will transfer funds electronically to the financial institution and account number you register on this EFT Authorization Agreement.
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 Authorization Agreement 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 Authorization agreement faxed to this number: **1-888-536-2324**
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 in this EFT Authorization Agreement.

Revised: 4/22/2015