TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29021-7039
Fax 803-462-3986

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TRICARE®
MARRIAGE AND FAMILY THERAPIST
PASTORAL COUNSELOR
PROVIDER APPLICATION

Please submit the completed application package to:

Fax:
803-462-3986

or

Mail to:
TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29021-7039

Note: TRICARE non-network provider data management will not reply to successful updates to our provider file. You may view and update your provider information by registering on myTRICARE.com. You may file claims after 30 days of submitting your application unless notified that we require additional information. Inquiring about the status of your application within this time frame may delay processing.

Authorization as a TRICARE provider does not include a network or contractual agreement with Humana Government Business. To become a TRICARE-contracted Network Provider for the South Region, please visit www.humana-military.com to inquire about joining the network.

Indicate the name and phone number of the person to contact if additional information is needed.

NAME: ______________________________ PHONE: ______________________________

EMAIL: ____

Revised 7/21/16

Humana. Government Business

TRICARE MARRIAGE AND FAMILY THERAPIST PASTORAL COUNSELOR APPLICATION

NAME: ____

SOCIAL SECURITY NUMBER: _________________________ NPI#: __________________________

Do you maintain a solo practice? ☐ YES ☐ NO

Date you began solo practice: ___/___/_____

Tax ID Number of solo practice: _________________________ NPI#: _________________________

Are you employed by the U.S. Government? ☐ YES ☐ NO

OFFICE LOCATION (Street Address):

____

____

____

BILLING ADDRESS (If different):

____

____

____

Office Tele. No: (____) ____-_____ ext. ______

Billing Tele. No: (____) ____-_____ ext. ______

I will be signing my own claim forms: ☐ YES ☐ NO

PRACTITIONER 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 Practitioner)

____
(Office Address)

____

____

_______________________________________	____
Signature: Authorized Individual for Clinic	Signature of Practitioner
_______________________________________	________________________
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 form.

MARRIAGE AND FAMILY THERAPIST SECTION

FAILURE TO COMPLETE ALL APPLICABLE PARTS OF THIS SECTION WILL RESULT IN DELAY AND OR DENIAL OF CERTIFICATION.

☐ I have a master's degree from an accredited educational institution in an appropriate behavioral science field with a mental health discipline.

SCHOOL NAME: ________________________________ DATE GRADUATED: ___/___/___

DEGREE: _____________________________

COURSE OF STUDY: _____________________________

☐ I am licensed/certified in the state in which I practice.
You must obtain a state license or certificate to be eligible for TRICARE reimbursement if it is offered by your state, even if the state program is on a voluntary basis.

ORIGINAL LICENSE DATE: ___/___/_____

CURRENT LICENSE EFFECTIVE DATES: FROM ___/___/_____ TO ___/___/_____

IF THE STATE IN WHICH YOU PRACTICE DOES NOT OFFER LICENSING OR CERTIFICATION FOR MARRIAGE AND FAMILY COUNSELING, THEN YOU MUST CERTIFY THAT:

☐ I am a full CLINICAL member of the American Association for Marriage and Family Therapy (AAMFT) or

☐ I meet the requirements to become a full CLINICAL member of the AAMFT.

I CERTIFY THAT I HAVE SUCCESSFULLY COMPLETED THE MINIMUM EXPERIENCE:

☐ Two hundred (200) hours of approved supervision in the practice of marriage and family counseling or pastoral counseling, ordinarily to have been completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision occurred preferably with more than one supervisor and should include a continuous process of supervision with at least three cases, AND one thousand (1,000) hours of clinical experience in the practice of marriage and family counseling or pastoral counseling under approved supervision, involving at least 50 different cases; OR

☐ One hundred-fifty (150) hours of approved supervision in the practice of psychotherapy, ordinarily to have been completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling or pastoral counseling, AND seven hundred-fifty (750) hours of clinical experience in the practice of psychotherapy under approved supervision, involving at least 20 cases.

PASTORAL COUNSELOR SECTION

FAILURE TO COMPLETE ALL APPLICABLE PARTS OF THIS SECTION WILL RESULT IN DELAY AND OR DENIAL OF CERTIFICATION.

☐ I have a master's degree from an accredited educational institution in an appropriate behavioral science field with a mental health discipline.

SCHOOL NAME: ________________________________ DATE GRADUATED: ___/___/___

DEGREE: ______________________________

COURSE OF STUDY: ______________________________

☐ I am licensed/certified in the state in which I practice.
You must obtain a state license or certificate to be eligible for TRICARE reimbursement if it is offered by your state, even if the state program is on a voluntary basis.

ORIGINAL LICENSE DATE: ___/___/_____

CURRENT LICENSE EFFECTIVE DATES: FROM ___/___/_____ TO ___/___/_____

IF THE STATE IN WHICH YOU PRACTICE DOES NOT OFFER LICENSING OR CERTIFICATION FOR PASTORAL COUNSELOR, THEN YOU MUST CERTIFY THAT:

☐ I am a fellow or diplomate member in the American Association for Pastoral Counselors (AAPC).

☐ I meet the requirements to become a fellow or diplomate member in the AAPC.

I CERTIFY THAT I HAVE SUCCESSFULLY COMPLETED THE MINIMUM EXPERIENCE:

☐ Two hundred (200) hours of approved supervision in the practice of marriage and family counseling or pastoral counseling, ordinarily to have been completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision occurred preferably with more than one supervisor and should include a continuous process of supervision with at least three cases, AND one thousand (1,000) hours of clinical experience in the practice of marriage and family counseling or pastoral counseling under approved supervision, involving at least 50 different cases; OR

☐ One hundred-fifty (150) hours of approved supervision in the practice of psychotherapy, ordinarily to have been completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling or pastoral counseling, AND seven hundred-fifty (750) hours of clinical experience in the practice of psychotherapy under approved supervision, involving at least 20 cases.

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 Defense Health Agency (DHA). 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 Defense Health Agency (DHA) guidelines, we may accept, in lieu of a provider's actual signature on a TRICARE claim form, a facsimile 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.

PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

STATE OF ___________________________ COUNTY OF __________________________________

_______________________________________ being first duly sworn, deposes and says:
I hereby authorize the Contractor for TRICARE to accept my facsimile or stamp signature shown below:

____
(Facsimile, stamp or computer-generated signature as it will appear on the claim form, type or print for electronic claims)

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 system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

____
(Provider 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 Defense Health Agency (DHA) guidelines, we may accept in lieu of a provider's actual signature on a TRICARE claim form, a facsimile signature. The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim is computer-generated.

TRICARE PARTICIPATION AGREEMENT FOR CERTIFIED MARRIAGE AND FAMILY THERAPISTS

____
(Name of Certified Marriage and Family Therapist)

____
(Office Address)

____

____

____
(Telephone)

____
(TRICARE Provider Billing Number)

ARTICLE 1
RECITALS

1.1 Identification of Parties

This Participation Agreement is between the United States of America through the Department of Defense, Defense Health Agency (hereinafter DHA), a field activity of the Office of the Secretary of Defense, the administering activity for the Defense Health Agency

(hereinafter DHA) and ____

doing business as ____,
(hereinafter designated certified marriage and family therapist(s).

1.2 Authority for Certified Marriage and Family Therapists as Authorized Providers

32 Code of Federal Regulations Part 199 provides for cost-sharing of services provided by certified marriage and family therapists under certain conditions.

1.3 Purpose of Participation Agreement

The purpose of this participation agreement is to:

(a) Establish the undersigned certified marriage and family therapist as an authorized provider of mental health services;
(b) Establish the terms and conditions that the undersigned certified marriage and family therapist must meet.

1.4 Billing Number

The certified marriage and family therapist's billing number for all mental health services rendered is the certified marriage and family therapist's social security number or employer's identification number (EIN). This billing number must be used until the provider is officially notified by DHA of a change. The certified marriage and family therapist's number is shown on the face sheet of this agreement. It is the only billing number that will be accepted by DHA claims processors after the effective date of this agreement for becoming an authorized certified marriage and family therapist.

ARTICLE 2
PERFORMANCE PROVISIONS

2.1 General Agreement

The certified marriage and family therapists agrees to render medically necessary and appropriate covered mental health services within the scope of his practice and licensure to eligible beneficiaries as required by this participation agreement and the 32 CFR 199.6. The terms and conditions of 32 CFR 199.6 applicable to the participation or treatment of beneficiaries by the certified marriage therapists are incorporated herein by reference.

2.2 Licensure and Certification Requirements

The certified marriage and family therapists certifies and attaches hereto documentation that:

(a) He/she is now licensed or certified to practice as a marriage and family therapists by the state in which practicing; or

(b) If practicing in a state which does not provide specific licensure or certification, the certified marriage and family therapist must be certified eligible for full clinical membership in the American Association for Marriage and Family Therapy; and

(c) He/she has a recognized graduate professional education with a minimum of an earned master's degree from an accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(d) He/she has the following experience:

(1) Either 200 hours of approved supervision in the practice of marriage and family counseling, ordinarily to be completed in a 2- to 3- year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

(2) 1000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases; or

(3) 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2 to 3 year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

(4) 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling under approved supervision, involving at least 20 cases.

2.3 The certified marriage and family therapist agrees that, having an exclusive election to participate as a certified marriage and family therapist, he or she will not be authorized in any other category of extra medical provider, either during or subsequent to the period this agreement is in effect.

ARTICLE 3
PAYMENT PROVISIONS

3.1 Determined Allowable Charge

The determined allowable charge is the maximum amount that can be authorized for services rendered by an authorized individual professional provider of care. The determined allowable charge is determined following the provisions set forth in 32 CFR 199.14.

3.2 Determined Allowable Charge as Payment in Full.

The certified marriage and family therapist agrees to accept the determined allowable charge as payment in full for services rendered to beneficiaries, except applicable deductible and cost-shares.

3.3 Hold Harmless

The certified marriage and family therapist agrees to hold eligible beneficiaries harmless for non-covered care (i.e., certified marriage and family therapist may not bill a beneficiary for non-covered care and may not balance bill the beneficiary for amounts above the determined allowable charge).

ARTICLE 4
TERM, TERMINATION AND AMENDMENT

4.1 Term

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated by either party.

4.2 Termination of Agreement by DHA

The Executive Director, DHA, or designee, may terminate this agreement upon written notice, for cause, if the certified marriage and family therapist is found not to be in compliance with the provisions set forth in 32 CFR 199.6, or is determined to be subject to the administrative remedies involving fraud, abuse, or conflict of interest as set forth in 32 CFR 199.9. Such written notice of termination shall be an initial determination for purposes of the appeal procedures set forth in 32 CFR 199.10.

4.3 Termination of Agreement By the Certified Marriage and Family Therapist

The certified marriage and family therapist may terminate this agreement by giving the Executive Director, DHA, or designee, written notice of such intent to terminate at least 60 days in advance of the effective date of termination. Effective the date of termination, the certified marriage and family therapist will no longer be recognized as an authorized provider, and reinstatement shall be disallowed for any other category of extramedical individual provider. Subsequent to termination, the certified marriage and family therapist may only be reinstated as an authorized extramedical provider by entering into a new participation agreement as certified marriage and family therapist.

4.4 Amendment by DHA

(a) The Executive Director, DHA or designee, may amend the terms of this participation agreement by giving 120 days notice in writing of the proposed amendment(s) except when necessary to amend this agreement from time to time to incorporate changes to the 32 CFR 199. When changes or modifications to this agreement result from changes to the 32 CFR 199 through rulemaking procedures, the Executive Director, TMA or designee, is not required to give 120 days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective.

(b) The certified marriage and family therapist, not wishing to accept the proposed amendment(s), including any amendment resulting from the changes to the 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the certified marriage and family therapist notice of intent to terminate its participation is not given at least 60 days *prior* to the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into this agreement for services furnished by the certified marriage and family therapist between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 5
EFFECTIVE DATE

5.1 Date Signed
This participation agreement is effective on the date signed by the Executive Director, DHA, or designee.

DHA	Certified Marriage and Family Therapist
______________________________	______________________________
By: Signed Name	By: Signed Name
______________________________	______________________________
Title	Title
______________________________	______________________________
By: Typed Name and Title	By: Typed Name and Title

Executed on ______________________, 20____

TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29021-7039
Fax 803-462-3986

Toll-Free: 1-800-403-3950
www.myTRICARE.com by PGBA

EFT ENROLLMENT

Dear Provider:

Thank you for your interest in Electronic Funds Transfer (EFT) with PGBA, LLC. Please take a moment to review the enrollment guidelines (Appendix A). Once you have reviewed the guidelines, please complete the enclosed enrollment form (Pages 2a & 3a) with all required information, along with the Terms and Conditions located on page 4a.

In addition to EFT, PGBA, LLC. also offers Electronic Remittance Advice (ERA) which requires a separate enrollment form. If you choose both transactions, you will need to contact your financial institution to arrange for the delivery of the CORE-required minimum CCD+ data elements necessary for successful reassociation of the EFT payment with the ERA remittance advice.

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 already have a myTRICARE secure account, please first log in, if you have not done so already. If you are not a registered myTRICARE secure account holder, please go to www.myTRICARE.com and register.

If you do not wish to enroll online, please fax your completed forms to:

PGBA, LLC
TRICARE Electronic Data Interchange
FAX: 803-462-3995

Please retain a copy of the completed enrollment form for your records.

Online instructions for checking the status of EFT enrollment can be found at www.myTRICARE.com

If you do not choose to receive an 835 file or paper remittance, you have the option of viewing your remittance online at www.myTRICARE.com. For assistance with signing up to view remits online, contact myTRICARE support at 1-866-698-7422.

Please note, if you are not a TRICARE authorized provider, or an incomplete form is submitted, the enrollment form will be returned to the provider with a letter stating the reason for return

Please allow 4 weeks for the enrollment process which includes pre-note verification. If after 4 weeks you do not start receiving EFT payments, contact South Region Customer Service at 1-800-403-3950.

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 South Region Customer Service.

We are committed to making your transition to EFT as smooth as possible. If you have any questions regarding the information contained in this package, please contact the Provider Data Management Department by fax to 1-803-462-3995, or call the South Region Customer Service at 1-800-403-3950.

EFT ENROLLMENT FORM

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)					

☐ **NOTE:** Checking this box indicates listing **all** locations for payment with a different physical address that are to be transmitted to the Financial Institution Transit/Routing and Account number listed above. 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

TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29021-7039
Fax 803-462-3986

Provider Contact Information					
Provider Contact Name					
Telephone Number					
Email Address					
Fax Number					
Financial Institution Information					
Financial Institution Name					
Financial Institution Address					
City		State		ZIP Code/ Postal Code	
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)					
Provider Tax Identification Number (TIN) **or** National Provider Number (NPI)					
Reason for Submission		☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment			
Authorized Signature					
Signature of Person Submitting Enrollment					
Printed Title of Person Submitting Enrollment					
Submission Date		Requested EFT Start/Change/Cancel Date			

TERMS AND CONDITIONS FOR ELECTRONIC FUNDS TRANSFER

By Signing below 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 Form 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 the attached EFT/ERA Enrollment Form.

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/ERA Enrollment Form 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 ERA Enrollment Form faxed to this number:

PGBA, LLC EFT
Fax: 1 803-462-3995

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 non-banking 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 below.

NAME: ______________________________ SIGNATURE: ______________________________
(Please Print)

TITLE: ______________________________ DATE: ___/___/___

TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29021-7039
Fax 803-462-3986

APPENDIX A
TRICARE SOUTH EFT ENROLLMENT
Form Completion Guidelines

Instructions for completing the EFT Enrollment form

- Please type or print legibly.
- Use only black or blue ink to complete paper form.
- Online form can be accessed at www.myTRICARE.com
- Please allow 4 weeks for enrollment process. If after 4 weeks you do not start receiving EFT payments, you may contact PDM Support at 1-800-403-3950 or go to www.myTRICARE.com for other contact information.

Provider Information

- **Provider Name** - Complete legal name of institution, corporate entity, practice or individual provider.
- **Provider Address**- associated with the institution, corporate entity, practice or individual provider.
- **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.

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 to be deposited.
- **Type of Account at Financial Institution**: - The type of account the provider will use 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 fill out one of the two options below:

- **Providers Tax Identification Number (TIN)** - as described in "Provider Identifiers".
- **National Provider Identifier (NPI)** - as described in "Provider Identifiers".

Reason for Submission **-** Must select one from below

- **New Enrollment**- indicating new enrollment.
- **Change Enrollment** - write a note stating the needed change and the requested ERA effective date of the change.
- **Cancel Enrollment** - provide requested ERA effective date of the cancellation.

Authorized Signature - The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment may be used with electronic and paper-based manual enrollment.

- **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 enrollment.
- **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.

ERA ENROLLMENT

Dear Provider:

Thank you for your interest in Electronic Remittance Advice (ERA) with PGBA, LLC. Please take a moment to review the enrollment guidelines (Appendix B). Once you have reviewed the guidelines, please complete the enclosed enrollment form (Pages 2b & 3b) with all required information.

In addition to ERA, PGBA, LLC also offers Electronic Funds Transfer (EFT), which requires a separate enrollment form. If you choose both transactions, you will need to contact your financial institution to arrange for the delivery of the CORE-required minimum CCD+ data elements necessary for successful reassociation of the EFT payment with the ERA remittance advice.

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 already have a myTRICARE secure account, please first log in, if you have not done so already. If you are not a registered myTRICARE secure account holder, please go to www.myTRICARE.com and register.

If you do not wish to enroll online, please fax or mail your completed forms to:

FAX: 803-264-9864
PGBA, LLC
TRICARE Electronic Data Interchange
PO BOX 17150
Augusta, GA 30903

Please retain a copy of the completed enrollment form for your records.

Online instructions for checking the status of ERA enrollment can be found at www.myTRICARE.com.

Please note, if you are not a TRICARE authorized provider, or an incomplete form is submitted, the enrollment form will be returned to the provider with a letter stating the reason for return.

Please allow 4 weeks for the enrollment process to be completed. If after 4 weeks you do not start receiving ERA files, you may contact the EDI Help Desk at 1-800-325-5920, Option #2 or by Email at EDI.TRICARE@PGBA.com.

Once enrolled, ERA files that have not been received after 4 business days of receipt of the corresponding EFT file or check payment can be researched by calling or Emailing the EDI Help Desk.

We are committed to making your transition to ERA as smooth as possible. Arrangements can be made for you to receive a paper copy of your remit in conjunction with an 835 transaction file for up to 31 days by contacting the EDI Help Desk.

If you have any questions regarding the information contained in this package, please contact our EDI Help Desk at 1-800-325-5920, Option #2 or by Email to EDI.TRICARE@PGBA.com.

ERA ENROLLMENT FORM

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)					
Other identifier(s)	Trading Partner ID		7GW _ _ _ _ _ _ _		

☐ **NOTE:** Checking this box indicates enrolling **all** locations for this provider's TIN/EIN that are active in our provider files and will no longer receive a paper remit. 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			
ELECTRONIC REMITTANCE ADVICE INFORMATION (See instructions)			
Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)	*Provider preference for grouping (bulking) claim payment advice – must match preference for EFT payment* **Select TIN or NPI and enter below:**		
Provider Tax Identification Number (TIN) **or** National Provider Number (NPI)			
Method of Retrieval			
ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION			
Clearinghouse Name			
Telephone Number			
Email Address			
SUBMISSION INFORMATION			
Reason for Submission	☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment		
Authorized Signature			
Written Signature of Person Submitting Enrollment			
Printed Title of Person Submitting Enrollment			
Submission Date		Requested ERA Effective Date	

APPENDIX B
TRICARE SOUTH ERA ENROLLMENT
Form Completion Guidelines

Instructions for completing the ERA Enrollment form

- Please type or print legibly.
- Use only black or blue ink to complete paper form.
- Online form can be accessed at www.myTRICARE.com

Provider Information

- **Provider Name** - Complete legal name of institution, corporate entity, practice or individual provider.
- **Provider Address-** Associated with institution, corporate entity, practice, or individual provider.
- **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.

Other Identifiers

- **Assigning Authority** - Organization that issues and assigns the additional identifier requested on the form.
- **Trading Partner ID** - The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor.

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.
- **Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)** - Provider preference for grouping (bulking) claim payments - must match preference for EFT payment.

- Must fill out one of the two options below:
- **Providers Tax Identification Number (TIN)** - as explained in "Provider Identifiers".
- **National Provider Identifier (NPI)** - as explained in "Provider Identifiers".

- **Method of retrieval** - Electronic remits can be retrieved in a HIPAA 835 file format directly or through a clearinghouse. Provider remits can also be viewed/downloaded from the myTricare web site if you are a member. Once set up for either method, paper remits will be stopped.

Clearinghouse Information

- **Clearinghouse Name** - Official name of the provider's clearinghouse.
- **Telephone Number** - Telephone number of contact.
- **Email Address** - An electronic mail address at which the health plan might contact the provider's clearinghouse.

Reason for Submission: Must select one from below

- **New Enrollment** - indicating new enrollment.
- **Change Enrollment** - write a note stating the needed change and the requested ERA effective date of the change.
- **Cancel Enrollment** - provide requested ERA effective date of the cancellation.

Authorized Signature - The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment may be used with electronic and paper-based manual enrollment.

- **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 enrollment.
- **Submission Date** - The date on which the enrollment is submitted.
- **Requested ERA Effective Date** - Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner.