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

Hospice
Provider Application Package

TRICARE
HOSPICE
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

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

NAME: _____ PHONE: _____

EMAIL: _____

Revised 11/4/14

Humana. Government Business

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Camden, SC 29021-7039
Fax 803-462-3986

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

TRICARE
HOSPICE APPLICATION

FACILITY NAME: _____

FEDERAL TAX NO: _____ NPI #: _____

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

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

_____ _____

_____ _____

_____ _____

Is the facility Medicare certified: ☐ YES ☐ NO If yes:

CERTIFICATION NO. (ORIGINAL): _____ CATEGORY: _____

ORIGINAL CERT. DATE:___/___/_____ CURRENT CERT. DATES:___/___/_____TO ___/___/_____

Is the facility JCAHO certified: ☐ YES ☐ NO If yes:

JCAHO CLASSIFICATION: _____

ORIGINAL CLASS. DATE:___/___/_____ CURRENT CLASS. DATES:___/___/_____TO ___/___/_____

STATE LICENSE CLASSIFICATION (ORIGINAL): _____

ORIGINAL LICENSE DATE:___/___/_____ CURRENT LICENSE DATES:___/___/_____TO ___/___/_____

*** YOU MUST ATTACH COPIES OF MEDICARE, JCAHO AND STATE LICENSING. ***

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

UB-04 "Signature on File Form"
For TRICARE Claims

Beginning January 1, 2008, all UB-04 paper claims submissions for TRICARE must include a signature on the claim form in order to process. The provider signature should be applied in the "Remarks Field (FL80) of the UB-04 claim form.

However, if you would like to eliminate the need to apply a signature in the remarks field on each and every claim submitted please complete this form and return it to the fax number provided.

In order to prevent delays in processing your TRICARE claims we are offering this"Signature on File Form."

Please provide the information requested below and fax this form to the PGBA fax number listed. Once received at PGBA, this completed form will be retained and applied for future claims submissions from your facility thus eliminating the need to apply a signature to each individual claim filed.

Facility Name: _____

Facility Tax Identification Number: _____

Signature of Authorized Representative: _____

Signature on this form certified that any changes submitted by the facility on a UB-04 are turn, accurate and correct. Signature on this form meets the policy requirement from TRICARE Operations Chapter 8, Section 10, as stated below and negates the need for a signature in block 80 of the UB-04.

"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 8/0, Remarks, as the location for the signature, if signature on file requirements does not apply to the claim. If a non-network participating claim does not contain an acceptable signature, return the claim."

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Camden, SC 29021-7039
Fax 803-462-3986

PARTICIPATION AGREEMENT
FOR HOSPICE PROGRAM SERVICES
FOR TRICARE BENEFICIARIES

_____
CORPORATE NAME

_____
DBA (if different from corporate name)

_____
LOCATION

_____
MAILING ADDRESS (If different from location)

_____
TELEPHONE

_____
PROVIDER EIN NO

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 Secretary of Defense, the administering activity for TRICARE/Civilian Health and Medical Program of Uniformed Services Management Activity (hereinafter DHA) and

_____, doing business as

_____,
(hereinafter designated the hospice program).

1.2 Authority for Hospice Care

The implementing regulations for TRICARE, 32 Code of Federal Regulations Part 199, provides for TRICARE cost-sharing of hospice care under certain conditions.

1.3 Intent of Participation Agreement

It is the intent of this participation agreement to recognize the undersigned hospice program as a TRICARE-authorized provider of hospice care, subject to terms and conditions of this agreement, and applicable federal law and regulation.

1.4 Billing Number

The number used for billing of all hospice care is the hospice program's employer identification number (EIN). This number must be used until the provider is officially notified by DHA of a change. The hospice program's billing 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 hospice program under TRICARE.

ARTICLE 2
PERFORMANCE PROVISIONS

2.1 General Agreement

The hospice program agrees to render palliative hospice care to eligible TRICARE beneficiaries as required by this participation agreement and the TRICARE regulation (32 CFR 199). The terms and conditions of 32 CFR 199 applicable to the participation or treatment of TRICARE beneficiaries by hospice programs are incorporated herein by reference.

2.2 Coverage/Benefits

(a) The hospice program agrees to provide the care and services set forth in 32 CFR 199.4(e)(l9)(i).

(b) The hospice program further agrees to provide for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the hospice program, except that the agency must:

(1) Routinely supply a substantial amount of core-services (i.e., nursing services; physician services; medical social services; and counseling) services for the TRICARE beneficiary and his or her family. (32 CFR l99.4(e)(l9)(ii))

(2) Maintain professional management responsibility of non-core services (i.e., home health aide services, medical appliances and supplies, physical therapy, occupational therapy, speech language pathology and short-term inpatient care) which are not directly furnished to the patient, regardless of the location or facility in which the services are rendered. (32 CFR 199.4(e)(19)(iii))

(3) Make nursing services, physician services, and drugs and biologicals routinely available on a 24-hour basis. All other covered services must be available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for palliation and management of the terminal illness and related condition. (32 CFR l99.4(e)(19)(iv))

(4) Provide assurances that the aggregate number of days of inpatient care provided in any 12-month period does not exceed 20 percent of the aggregate number days of hospice care during the same period.

(5) Have an interdisciplinary group (i.e., one physician; one registered nurse; one social worker; and one pastoral or other counselor) who provides those services set forth in 32 CFR 199.4(e)(19)(i) and establishes the policies governing the provision of such services/care.

(6) Maintain central clinical records on all patients.

2.3 Conditions for Coverage

Under the terms of this agreement, the hospice program shall:

(a) Assure that there is written certification in the medical records that the TRICARE beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

(1) For the initial 90-day period, the hospice must obtain written certification statements from the individual's attending physician (if the individual has an attending physician) and the medical director of the hospice or the physician member of the hospice interdisciplinary team no later than two days after the period begins. If written certifications cannot be obtained within two calendar days, then oral certification must be obtained within two calendar days, followed by written certification no later than eight calendar days after hospice care is initiated.

(2) Recertification is required for any subsequent periods (for periods two, three and four) of hospice care for which the beneficiary is eligible. The hospice medical director or staff physician will be responsible for recertifying TRICARE beneficiaries for subsequent election periods. A written certification must always be in the medical records not later than two days after hospice care is initiated.

(b) Design and print its own election statements to include the following information:

(1) identification of the particular hospice that will provide care to the individual;

(2) individual's or representative's acknowledgement that he or she has been given a full understanding of hospice care;

(3) individual's or representative's acknowledgement that he or she understands that certain TRICARE services are waived by the election;

(4) effective date of election; and

(5) signature of the individual or representative.

(c) Assure that an election statement is in the clinical records prior to signing the Notice of Admission. This includes the admission date, which must be the same date as the effective date of the hospice election. The hospice program must notify the contractor of the initiation, change or revocation of any election.

(d) Establish a written plan of care on the same day that a member of the basic interdisciplinary group assesses the patient's needs. The attending physician and medical director or physician designee must review the initial plan of care and provide their input within two calendar days following the day of the assessment.

2.4 Certification Requirements

The hospice program certifies and attaches hereto documentation that:

(a) it is Medicare approved and meets all Medicare conditions of participation (42 CFR 418); and
(b) is licensed pursuant to any applicable state or local law.

2.5 Quality of Care

(a) The hospice program shall assure that any and all eligible beneficiaries receive hospice services that are reasonable and necessary for the palliation or management of a terminal illness and meet the conditions for coverage as established in Article 2.3 above.

(b) The hospice program shall provide hospice services in the same manner to TRICARE beneficiaries as it provides to all patients to whom it renders service.

(c) The hospice shall not discriminate against TRICARE beneficiaries in any manner, including admission practices or provisions of special or limited treatment.

2.6 Billing Form

(a) The hospice program shall use the UB-92 billing form (or subsequent editions.) Hospice care shall be identified in item 4 of this form.

(b) The UB-92 billing form (or subsequent editions) will also use as an admission notice. This notice will be used to notify the contractor of the initiation, change or revocation of an election.

2.7 Compliance with DHA Medical Review Activities

(a) Submit all medical records and documentation to the contractor and, where applicable, to the Peer Review Organization within 30 days of the date of their request.

(b) Failure to submit the requested information will result in denial of the claim.

2.8 Staff Qualifications

The hospice shall comply with requirements for professional staff qualifications as established in 32 CFR 199.4 and 32 CFR 199.6.

ARTICLE 3
PAYMENT PROVISIONS

3.1 The hospice program agrees to accept reimbursement at one of four predetermined national TRICARE rates (32 CFR 199.14(9)) adjusted for regional wage differences using appropriate Medicare wage indices as payment in full, except for physician-directed services and applicable cost-shares. The hospice will be reimbursed for an amount applicable to the type and intensity of the services furnished (i.e., routine home care, continuous home care, inpatient respite care and general inpatient care) to the TRICARE beneficiary on a particular day.

(a) One rate will be paid for each level of care, except for continuous home care where reimbursement is based on the number of hours of continuous care furnished on a particular day. The following requirements must be met in order to receive reimbursement for continuous home care:

(1) More than half of the period of continuous care must be provided by either a registered or licensed practical nurse.

(2) A minimum of 8 hours must be provided during a 24-hour day which begins and ends at midnight. If less than 8 hours of care are provided within a 24 hour period, the care will be paid at the lower routine home care rate.

(b) Payment for inpatient respite care may be for a maximum of 5 days at a time, including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

(c) The hospice program agrees to submit all claims as a participating provider. DHA agrees to make payment of the TRICARE-determined rate directly to the hospice program for any care authorized under this agreement.

(d) There may be a reclassification of care from one rate category to another as a result of medical review of hospice claims. For example, if continuous home care is provided to a TRICARE beneficiary whose condition did not require the level of care described in 32 CFR 199.14 (or did not receive it), payment is made for the services at the routine home care rate.

3.2 Physician reimbursement is dependent on the physician's relationship with both the beneficiary and the hospice program.

(a) Physicians employed by, or contracted, with, the hospice

(1) Administrative and supervisory activities (i.e., establishment, review and updating of plans of care, supervising care and services, and establishing governing policies) are included in the adjusted national payment rate.

(2) Direct patient care services are subject to the appropriate TRICARE allowable charge methodology and are counted toward cap limitation.

(b) Independent attending physician. Patient care services rendered by an independent attending physician (a physician who is not considered employed by, or under contract with, the hospice) are not part of the hospice benefit and may be billed in his/her own right.

(1) Services are subject to the appropriate allowable charge methodology but not counted toward the cap limitation.

(2) Services must be coordinated with any direct care services provided by hospice physicians.

(3) The hospice must notify the contractor of the name of the physician whenever the attending physician is not a hospice employee.

(c) No payments are allowed for physician services furnished voluntarily (both physicians employed by, and under contract with, the hospice and independent attending physicians). Physicians may not discriminate against TRICARE beneficiaries;e.g., designate all services rendered to non-TRICARE patients as volunteer and at the same time bill for TRICARE patients.

3.3 The hospice program agrees to the cap and inpatient limitations as prescribed in 32 CFR l99.l4 (g)(3).

(a) The hospice program further agrees to furnish such information as the contractor deems necessary for calculation and application of the cap amount and inpatient limitations within 30 days after the end of the cap period.

(b) Payments in excess of the cap and/or inpatient limitations must be refunded by the hospice.

(c) A hospice may request and obtain a contractor's review of calculation and application of its cap amount and inpatient limitation if the amount in controversy meets the administrative dollar level established in 32 CFR 199.14(g)(3). These calculations are not subject to the appeal procedures set forth in 32 CFR 199.10.

3.4 The hospice program agrees to hold eligible TRICARE beneficiaries harmless (not to charge the beneficiary) for the following services:

(a) those for which the provider is entitled to payment from TRICARE;

(b) those for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements (e.g., election notification, care plan and submission of requested records within 30 days);

(c) those which are not necessary for the palliation or management of the terminal illness; NOTE: If the patient is informed that the services are not covered under the TRICARE hospice benefit and continues to insist that it be performed, he or she will be liable for payment. The above item only applies to those services and supplies prescribed by the hospice.

(d) those for which a beneficiary would be entitled to payment, but for a reduction or denial in payment as a result of quality review;

(e) those rendered during a period in which the hospice was not in compliance with one or more conditions for coverage.

3.5 TRICARE as Secondary Payor

(a) The hospice program is subject to the provisions of 10 USC Section 1079(j)(1). The hospice program must submit claims first to all other insurance plans and/or medical service or health plans under which the beneficiary has coverage before submitting a claim to TRICARE.

(b) Failure to collect first from primary health insurers and/or sponsoring agencies is a violation of this agreement, may result in denial or reduction of payment, and may result in a false claim against the United States. It may also result in termination by DHA of this agreement pursuant to Article 5.

3.6 Collection of Cost-Share

(a) The hospice program agrees to collect from the TRICARE beneficiary only those amounts applicable to the patients cost-share as defined in 32 CFR l99.14(g)(8).

(b) The collection of cost-shares by individual hospice programs is optional under TRICARE The waiver of cost-sharing will not be considered fraudulent billing under 32 CFR 199.9.

3.7 Beneficiary's Rights

If the hospice program fails to abide by the terms of this participation agreement and DHA or its designee either denies the claim or claims and/or terminates the agreement as a result, the hospice agrees to forego its rights, if any, to pursue the amounts not paid by TRICARE from the beneficiary or the beneficiary's family.

ARTICLE 4
RECORDS AND AUDIT PROVISIONS

4.1 On-Site and Off-Site Reviews/Audits

The hospice program grants the Executive Director, DHA or designee the right to conduct quality assurance audits or accounting (record) audits with full access to patients and records. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. The right to audit/review includes, but is not limited to:

(a) Examination of fiscal and all other records of the hospice program which would confirm compliance with this agreement and designation as an authorized TRICARE hospice provider.

(b) Audits of hospice program records including clinical, financial, and census records to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided TRICARE beneficiaries. DHA or a designee shall have full access to records of both TRICARE and non-TRICARE patients.

(c) Examination of reports of evaluations and inspections conducted by federal, state, local government and private agencies and organizations

4.2 Right to Unannounced Inspection of Records

(a) DHA or its designee, shall have the authority to visit and inspect the hospice program at all reasonable times on an unannounced basis.

(b) The hospice program's records shall be available and open for review by DHA during normal working hours (8am to 5pm, Monday through Friday) on an unannounced basis.

4.3 Certified Cost Reports

Upon request, the hospice program shall furnish DHA or a designee audited cost reports certified by an independent auditing agency.

4.4 Records Requested by DHA

Upon request, the hospice program shall furnish DHA or a designee such records, including medical records and patient census records, that would allow DHA or a designee to determine the quality and cost effectiveness of care rendered.

4.5 Failure to Comply

Failure to allow audits/reviews and/or to provide records constitutes a material breach of this agreement. It may result in denial or reduction of payment, termination of this agreement pursuant to Article 6, and any other appropriate action by DHA.

ARTICLE 5
GENERAL ACCOUNTING OFFICE

5.1 Right to Conduct Audit

The hospice program grants the United States General Accounting Office the right to conduct audits.

ARTICLE 6
TERMINATION AND AMENDMENT

6.1 Termination of Agreement by DHA

(a) The Executive Director, DHA, or designee, may terminate this agreement upon 30 days written notice, for cause, if the hospice program is not complying substantially with the provisions of this agreement or with applicable provisions set forth in 32 CFR 199. Causes for termination include violation of patient charging and cost reporting procedures, refusal to provide required program information or willfully providing false information, failing to meet the Conditions of Participation, and 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. NOTE: The notice provisions in this article do not limit DHA's authority to suspend claims processing or seek recoupment of claims previously paid.

(b) After termination of the agreement, the hospice program may not file another agreement to participate unless TRICARE finds that the reason for termination of the prior agreement has been removed and that there is reasonable assurance that it will not recur.

6.2 Termination of Agreement by the Hospice Program

The hospice program may terminate this agreement by giving the Executive Director, DHA, or designee, written notice of such intent to terminate at least 6 months in advance of the effective date of termination. If the hospice program permanently or temporarily ceases to furnish services to the community, the agreement terminates effective with the data the program goes out of business.

6.3 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 TRICARE regulation. When changes or modifications to this agreement result from

changes to the TRICARE regulation through rulemaking procedures, the Executive Director, DHA, 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 or the date this agreement is amended, whichever date is earlier.

(b) The hospice program, not wishing to accept the proposed amendment(s), including any amendment resulting from changes to the TRICARE regulation accomplished through rulemaking procedures, may terminate its participation as provided in this Article. However, if the hospice program's notice of intent to terminate its participation is not given at least 6 months 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 hospice program between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 7
CHANGE OF OWNERSHIP

7.1 Change of ownership

(a) When an organization having a provider agreement undergoes a change of Ownership the agreement is automatically assigned to the successor provider.

(b) A change of ownership occurs whenever there is a transfer of ultimate responsibility for operational decisions of the institution to a different governing body; for example:

(1) Where a sole proprietor transfers title and property to another party;

(2) Where, in the case of a partnership, the addition, removal, or substitution of a partner effects a termination of the partnership and creates a successor partnership or other entity;

(3) Where an incorporated provider merges with another incorporated institution nor participating in the program, and the non-participating institution is the surviving corporation;

(4) Where two or more corporate providers consolidate, and such consolidation results in the creation of a new corporate entity; or

(5) Where an unincorporated provider (a sole proprietorship or partnership) becomes incorporated.

(c) The contractor must be notified in advance of any expected changes in ownership.

ARTICLE 8
APPEALS

8.1 Appeal Actions

Appeal of DHA actions under this agreement, to the extent they are allowable, will be pursuant to 32 CFR 199.10.

ARTICLE 9
RECOUPMENT

9.1 Recoupment

DHA shall have the authority to suspend claims processing or seek recoupment of claims previously paid as specified under the provisions of the Federal Claims Collection Act (31 USC 3701 etseq.), the Federal Medical Care Recovery Act (42 USC 2651-2653), and 32 CFR 199. Payments in excess of the cap and/or inpatient limitations are subject to the provisions as set forth above.

ARTICLE 10
NONDISCRIMINATION

10.1 Nondiscrimination

The hospice program agrees to comply with provisions of Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112; as amended) regarding nondiscrimination on the basis of handicap, Title VI of the Civil Rights Act of 1964 (Public Law 88-352), and with the Americans With Disabilities Act of 1990 (Public Law 101-336), as well as all regulations implementing these Acts.

ARTICLE 11
ORDER OF PRECEDENCE

11.1 Order of Precedence

If there is any conflict between this agreement and any Federal statute or Federal Regulation, including the TRICARE/CIIAMPUS regulation, 32 CFR Part 199 and Medicare Conditions of Participation (42 CFR 418), the statute or regulation controls.

ARTICLE 12
DURATION

12.1 Duration

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until such time as there is a voluntary or involuntary termination.

ARTICLE 13
EFFECTIVE DATE

13.1 Date Signed

(a) This participation agreement will be effective on the date signed by the Executive Director, DHA, or designee.

(b) This agreement must be signed by the President or Chief Executive Officer of the corporation that owns the hospice program and must be accompanied by a resolution of the hospice program's Board of Director authorizing the signature.

ARTICLE 14
AUTHORIZED PROVIDER

14.1 Date Recognized

On the effective date of the agreement, DHA recognizes the hospice program as an authorized provider for purposes of providing hospice care to TRICARE eligible beneficiaries.

_____
Hospice Program

By: _____
Signature

_____
Type Name & Title

_____
Corporate Name

Executed on _____, 20____

_____
DHA

By: _____
Signature

_____
Type Name & Title

Executed on _____, 20____

HOSPICE FACT SHEET

1. NAME OF HOSPICE PROGRAM:

_____

2. EMPLOYER IDENTIFICATION NUMBER (EIN)/IRS TAX NUMBER:

_____

3. OFFICE LOCATION (STREET ADDRESS)

_____

_____

_____

_____

BILLING ADDRESS:

_____

_____

_____

_____

4. ROUTINE PHONE NUMBER:

_____

5. EMERGENCY PHONE NUMBER

_____

REMINDER: The enclosed participation agreement must be completed and signed before TRICARE can authorize the Hospice Program.

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

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.

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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			

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

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: ___/___/___

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.

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

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.

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

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.