TRICARE West Region Electronic Funds Transfer (EFT) Authorization Request

To be eligible to receive an EFT from TriWest, you must be a Network Provider who receives electronic remittance. Please select the appropriate REMITTANCE OPTION below, and then *attach* this cover page to the appropriate EFT/ERA Authorization forms and mail to WPS.

By enrolling in TRICARE West Region Electronic Funds Transfer (EFT):

- You will receive quicker payment for services provided to TRICARE West Region beneficiaries.
- Funds will be deposited directly to your checking or savings account.
- Your paper check is replaced, eliminating potential delay and inconsistencies with mail procedures.

WPS will complete the pre-note process with your bank to ensure a problem-free conversion to EFT for your office once the completed EFT Authorization form is received. Please note that your paper Explanation of Benefits (EOB) will no longer be mailed 45 days after your EFT becomes effective.

In order to receive Electronic Funds Transfer for TRICARE claims payments, your office will also need to register to receive Electronic Remittance Advice (ERA) or view your Explanation of Benefits (EOB) and Provider Summary Reports containing payment information on our website at http://www.wpsic.com/edi/tools.shtml.

Please select your preferred REMITTANCE OPTION from the list below:

____ I am *already enrolled* to receive TRICARE West Region ERA, either through my clearinghouse or directly from WPS.

My receiver ID is: _____

Please ATTACH your completed EFT Authorization form to this cover page and mail these documents together to WPS.

____ I would like to begin receiving TRICARE West Region ERA through my clearinghouse.

My receiver ID is: _____

Please contact your clearinghouse for their specific enrollment procedures. ATTACH the completed ERA Authorization from your clearinghouse (or our enclosed ERA document) to the completed EFT Authorization form. Mail each of these documents together with this cover page to WPS.

____ I would like to begin receiving TRICARE West Region ERA from WPS directly to my office.

My receiver ID is: _____

Please ATTACH your completed ERA Authorization form and EFT Authorization form to this cover page and mail these documents together to WPS.

____ I will register on www.TriWest.com to view/print my claim payment information.

Please ATTACH your completed EFT Authorization form to this cover page and mail these documents together to WPS.

EFT and ERA Authorization forms may also be obtained from the WPS website: http://www.wpsic.com/edi/tools.shtml and on the TriWest website at: http://www.triwest.com/en/provider/edieraeft/forms/eft-form/EFTForm.pdf for EFT and http://www.triwest.com/en/provider/edieraeft/forms/electronic-remittance-advice/edi_ern_wps.pdf

INSTRUCTIONS FOR COMPLETING THE ELECTRONIC FUNDS TRANSFER AUTHORIZATION AGREEMENT

All Electronic Funds Transfer requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any TRICARE direct deposits are made.

PART I – REASON FOR SUBMISSION

Indicate if this is a new EFT authorization or change to your existing account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

PART II – IDENTIFICATION DATA

Line 1: Enter the name of the physician or individual practitioner or the legal business name of the provider/supplier as reported to the Internal Revenue Service (IRS). The account must be solely in the name of the physician or individual practitioner or in the legal business name of the person or entity.
Line 2: Enter the provider's/supplier's legal business name. The account to which EFT payments made must be solely in the name of the physician or individual practitioner or in the legal business name of the person or entity.
Line 3: Enter the chain organization's name.
Line 4: Enter the home office legal business name if different from the chain organization name.
Line 5: Enter the TAX Identification Number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security number.
Line 6: Enter the Pay To/Payment locations requesting EFT. Attach additional sheet if necessary. Street/City/State/Zip Code

1. If you choose the TAX ID option on ERAs and want to receive EFT for the same option, you are giving WPS permission to set up any location currently set up on the TRICARE provider file that is affiliated with this TAX ID and all NPIs associated with this TAX ID.
2. If you choose the Specific Group NPI & Pay To/Payment Location(s) for ERA and want to receive EFT for the same option, only the specific pay to/payment locations that you specify will be set up for ERA & EFT. Please add additional sheet if necessary.

Line 7A: Enter the 10-digit Group NPI number. The NPI is required to process this form.
Line 7B: Enter the Pay To/Payment locations requesting EFT. Attach additional sheet if necessary.

PART III – DEPOSITORY INFORMATION (Financial Institution)

Line 8: Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds).
Line 9: Enter the account holder's name.
Line 10: Enter the account holder's street address.
Line 11: Enter the account holder's city, state and ZIP code.
Line 12: Enter the bank or financial institutional telephone number.
Line 13: Enter the bank or financial institutional nine-digit routing number.
Line 14: Enter the depositor's account number and select the account type.

If you do not submit this information, your EFT authorization agreement will be returned without further processing.

PART IV – CONTACT PERSON

Enter the information for the contact person responsible for this EFT authorization agreement.

PART V – AUTHORIZATION

Line 21 – By your Signed Original signature on this form you are certifying that the account is drawn in the name of the physician or individual practitioner or in the legal business name of the provider or supplier. The provider or supplier has sole control of the account to which EFT deposits are made in accordance with all applicable regulations and instructions. Arrangements between the depository and the provider or supplier are in accordance with applicable regulations and instructions with the effective date of the EFT authorization. You must notify WPS regarding any changes in the account in sufficient time to allow WPS and the depository to act on changes. The EFT authorization form must be signed and dated by the same Authorized Representative. Mail this form with the original signature (no facsimile signatures can be accepted) to WPS.

WPS TRICARE WEST REGION ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I – REASON FOR SUBMISSION

Reason for Submission:

- ☐ New EFT Authorization
- ☐ Revision to Current Authorization (e.g. account or bank changes)
- ☐ EFT Termination Request

PART II – PROVIDER OR SUPPLIER INFORMATION

Name

Provider/Supplier Legal Business Name

Chain Organization Name

Home Office Legal Business Name
(if different from Chain Organization Name)

Tax Identification Number

Please choose only one option below:

_____ TAX ID Choose this option if you want all locations under this TAX ID.

OR

_____ Specific Group NPI & Pay To/ Payment Location(s)

Choose this option for a specific group NPI location(s) and list them below. If you have additional locations, please attach. Please include Pay To/ Payment Address.

GROUP NPI - (National Provider Identifier)	PAY TO / PAYMENT ADDRESS
1.	
2.	
3	

PART III – DEPOSITORY INFORMATION (Financial Institution)

Depository Name

Account Holder's Name

Account Holder's Street Address

City State Zip

Depository Telephone Number

Depository Contact Person

Depository Routing Transit Number (nine digit)

Depository Account Number

Type of Account (check one) ☐ Checking Account ☐ Savings Account

Please include a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type, and, if the information is provided on bank letterhead, a bank officer's signature. This information will be used to verify your account number.

PART IV – CONTACT PERSON

First Name | Middle Initial | Last Name

Telephone Number | Fax Number (if applicable)

Address Line 1 (Street Name and Number)

Address Line 2 (Suite, Room, etc.)

City/Town | State | Zip

E-mail Address

PART V – AUTHORIZATION

I hereby authorize Wisconsin Physicians Service Insurance Corporation (hereinafter "WPS"), to initiate credit entries and, in accordance with 31 CFR § 210.6(f), to initiate adjustments for any credit entries made in error to the account identified in Part III, above (hereinafter the "Account"). I hereby authorize the financial institution named in Part III, above (hereinafter the "Depository"), to credit and/or debit the Account.

If payment is being made to an account controlled by a Chain Home Office, I authorize the forwarding of TRICARE West Region payments to the Chain Home Office and acknowledge that this is considered payment to the provider or supplier.

If the account is drawn in an individual's name or the legal business name of the provider or supplier, I certify that the provider or supplier has sole control of the Account and certify that all arrangements between the Depository and the provider or supplier are in accordance with all applicable TRICARE regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until WPS has received written notification from me of its termination at least 30 days in advance as to afford WPS and Depository a reasonable opportunity to act on the notice of termination. WPS will continue to send the direct deposit to the Depository indicated above until notified by me that I wish to change the Depository receiving the direct deposit. If my Depository information changes, I agree to submit to WPS an updated EFT Authorization Agreement.

Original Signature Line

Authorized/Delegated Official Name (Print)

Authorized/Delegated Official Title

Authorized/ Delegated Official Original Signature | Date

Only a **Signed Original** document will be accepted.

Please, return your completed form(s) with (ORIGINAL SIGNATURES) to:

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
1717 W. Broadway
Madison, WI 53708-8128