TRICARE NON-NETWORK CORPORATE SERVICES PROVIDER APPLICATION

*We expect providers to submit claims electronically. If it is necessary to submit a paper claim, the only acceptable forms are the approved **red and white** NUCC 1500 (02-12) form and the NUBC UB-04 (CMS -1450) forms. These forms must include the instructions on the back page.*

Please submit the completed application package to:

Fax: 844-730-1373

or

Mail to:

TRICARE West

Provider Data Management

PO Box 202106

Florence, SC 29502-2106

*Health Net Federal Services offers payments and remittances by National Provider Identifier (NPI) number. **The NPI billed on the claim will determine where payment and remittance will be sent.** It is critical the information provided matches how your office will file claims. Inconsistent data will negatively impact claims payment.*

*If your business requires multiple mailing/payment addresses, please provide an NPI for each. **If you have more than one NPI, you must complete a separate application for each NPI number.***

Revised: 6/07/2023

TRICARE CORPORATE SERVICES PROVIDER APPLICATION

Facility Name: _____

Corporate/Foundation Name (if different): _____

Federal Tax ID No: _____ NPI: _____

Telephone number: _____ Facsimile number: _____

Physical Location (Street Address): Billing Address for this NPI:

_____ _____

_____ _____

_____ _____

Date legal entity established _____

Are you a MEDICARE provider? _____ Yes _____ No

If yes: MEDICARE Certification no: _____

MEDICARE category: _____

MEDICARE acceptance date: _____

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

Original classification date: _____

Current JCAHO classification dates FROM: _____ TO: _____

State license classification: _____

Dates of state licensure FROM: _____ TO: _____

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

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

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

TRICARE CORPORATE SERVICE PROVIDER APPLICATION

PLEASE CHECK APPROPRIATE BOX:

____ RADIATION THERAPY

____ CARDIAC CATHETERIZATION CLINIC

____ FREESTANDING SLEEP DISORDER DIAGNOSTIC CENTER
(If certified by the American Academy of Sleep Medicine (AASM), attach copy of certification)

____ INDEPENDENT PHYSIOLOGICAL LABORATORIES

____ FREESTANDING MRI CENTERS

____ COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

____ FREESTANDING BONE MARROW TRANSPLANT CENTER

____ HOME INFUSION

____ DIABETIC OUTPUT SELF MANAGEMENT EDUCATION PROGRAM
(Attach copy of certification from the American Diabetes Association [ADA])

____ HOME HEALTH AGENCY - In order to meet the certification requirements as a TRICARE authorized HHA CSP, the facility must attest to the following criteria:

The TRICARE Reimbursement Manual, Chapter 12, Section 1, paragraph 3.2.5.3 states: "Home Health Agencies (HHA) for which Medicare-certification is not available due to the specialized beneficiary categories they service (e.g., those HHAs specializing solely in the treatment of TRICARE eligible beneficiaries that are under the age of 18 or receiving maternity care) must meet the qualifying conditions for corporate service provider (CSP) status as specified in the TPM, Chapter 11, Section 12.1."

By signing the below, you attest to meeting these qualifying conditions under TRICARE terms and understand the criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States (Federal laws 18 U.S.C. 287 and U.S.C. 1001).

HHA's signature: _____ Date: _____

Application for TRICARE-Provider Status

CORPORATE SERVICES PROVIDER

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

Directions:

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

TRICARE West PDM
PO Box 202106
Florence, SC 29502-2106
OR
Fax: 844-730-1373

For inquiries, please call the toll-free 844-866-WEST.

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

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

_____ _____
Chief Executive Officer Date

PARTICIPATION AGREEMENT

In order to receive payment under TRICARE, _____

dba _____, as the provider of services agrees:

1. Not to charge a beneficiary for the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Defense Health Agency (DHA) agrees to:

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

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

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

This agreement may be terminated by either party by giving the other party written notice of termination. The provider shall also provide written notice to the public. Such notice of termination is to be received by the other party no later than 45 days prior to the date of termination. In the event of transfer of ownership, this agreement is assigned to the new owner, subject to the conditions specified in this agreement and pertinent regulations.

FOR PROVIDER OF SERVICES BY:		FOR DHA BY:	
_____		_____	
Name		Name	
_____	_____	_____	_____
Title	Date	Title	Date

_____
(TIN)

_____
(NPI)

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

Please complete the following information and return by fax to 844-730-1373

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

> “The signature of the non-network provider, or an acceptable facsimile, is required on all participating claims. The provider’s signature block Form Locator (FL) has been eliminated from the CMS 1450 UB-04. As a work around, the National Uniform Billing Committee (NUBC) has designated FL 80, Remarks, as the location for the signature, if signature on file requirements do not apply to the claim. If a non-network participating claim does not contain an acceptable signature, return the claim.”

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

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

Facility Name: _____

Facility Tax Identification Number: _____

Facility NPI Number: _____

Facility Physical Address: _____

Facility Phone Number: _____

Signature of Authorized Representative: _____

Revised: 6/07/2023