TRICARE
NON-NETWORK STATE VACCINE PROGRAM
SUPPLIER 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.***

Non-Network State Vaccine Supplier Application

State Vaccine Program Name: _____

Tax ID Number: _____ NPI#: _____

What is your assessment methodology (must check one for Reimbursement per TRICARE Reimbursement Manual, Chapter 1)

_____ Per Capita _____ Dosage-Based

Physical Address (Street Address):

_____

_____

_____

Billing Address for this NPI:

_____

_____

_____

** If you practice at multiple locations, please attach a list of additional office locations.

Telephone #: _____

Billing Telephone #: _____

Fax #: _____

Email: _____

Effective date of the Tax ID number or EIN (Date legal entity established): _____

Do you sign your own claim forms? _____ Yes _____ No

If No, Signature Authorization forms are attached. Please complete these forms and have them notarized for each practitioner. Without signature authorization forms on file, each claim will require a physical signature from the rendering provider and claims without signature will be returned without processing the claim for payment.

TRICARE PARTICIPATION AGREEMENT FORSTATE VACCINE PROGRAMS (SVPs)

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 entitles 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 or 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 amounts payable by, or on behalf or, the beneficiary, as full payment for TRICARE allowed services;

4. To permit access by the 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; (this requirement may not apply to a SVP participation agreement);

5. To provide to the 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;

6. 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;

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

8. 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

9. 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/copayment, and deductible amounts.

This agreement shall be binding on the provider and DHA upon acceptance by the Deputy 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 late 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:

_____
Name

_____
Title Date

_____
(TIN)

_____
(NPI)

For DHA by:

_____
Name

_____
Title Date

PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

State of _____

County of _____

_____ being first duly sworn, deposes and says: I hereby authorize PGBA, LLC / Health Net Federal Services in the state of South Carolina to accept my facsimile or stamp signature shown below.

(Facsimile, stamp or computer generated signature as it will appear on the claim form.)

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.

_____
Signature

Subscribed and sworn to before me this _____ day of _____ 20____.

_____
Notary Public in and for

_____ County, State of _____

(SEAL)

My Commission expires _____

Revised: 12/6/2017

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 _____ 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 TRICARE. 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, State of _____

(SEAL)

My Commission expires _____

Revised: 12/6/2017