Print Form

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

Physician
Provider Application Package

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TRICARE®
PHYSICIAN / DENTIST / PODIATRIST / OPTOMETRIST
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

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: CREDENTIALING DEPARTMENT PHONE: _____

EMAIL: _____

Revised 11/4/14

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TRICARE
PHYSICIAN APPLICATION

NAME: _____

SOCIAL SECURITY NUMBER: _____ NPI#: _____

Do you maintain a solo practice? YES NO

IF YOU ARE SOLO INCORPORATED, PLEASE GIVE EIN NUMBER: _____

*Date you began solo practice ____/____/____

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

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TRICARE PHYSICIAN APPLICATION

License No.: _____ Permanent ✔ Temporary/Limited

Original License Date: ___/___/___ Current Effective Dates: FROM ___/___/___ TO ___/___/___

Primary Specialty: _____

Are you a:			LOCATION:
Christian Science Practitioner?	YES	✔NO	_____
Hospital-based Physician?	YES	✔NO	_____
Teaching-setting Physician?	YES	✔NO	_____
Employed by the U.S. Government?	YES	✔NO	_____
National Health Service Corp. Physician?	YES	✔NO	_____

Are you an INTERN? YES ✔NO Are you a RESIDENT? YES ✔NO

If RESIDENT, name of facility where you are completing your residency:

_____

BEGIN DATE: ___/___/_____ COMPLETION DATE: ___/___/_____

Tax ID Number: _____ NPI#: _____

If RESIDENT, are you providing services in a setting other than the hospital or institution where you are employed (i.e. "moonlighting")?: YES NO

If YES, identify location: _____

Tax ID Number: _____ NPI#: _____

Are you transferring from another state where you had an established practice?: YES NO

If YES, State: _____ Provider Number: _____

What date did you begin your first Practice for which payment was made outside the scope of an intern or training program (i.e. date you began practicing after you completed your residency)?

___/___/_____

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PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

STATE OF FLORIDA _____ COUNTY OF Hernando _____

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 Hernando _____ STATE OF FLORIDA _____

(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.

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PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

STATE OF FLORIDA _____ COUNTY OF Hernando _____

_____ 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 Hernando _____ STATE OF Florida _____

(SEAL)

MY COMMISION 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.

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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.

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