TRICARE
PHYSICIAN/DENTIST
PROVIDER APPLICATION

Before submitting an application, please note physicians and dentists can be loaded to our provider file via claims submissions in lieu of an application. TRICARE will use online resources to confirm you meet TRICARE criteria.

Please submit the completed application package to:

Fax: 888-279-3540

or

Mail to:
TRICARE North Region
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756

Note: TRICARE non-network provider data management will not reply to successful updates to our provider file. You may view and update your provider information by registering on myTRICARE.com. You may file claims after 30 days of submitting your application unless notified that we require additional information. Inquiring about the status of your application within this timeframe may delay processing.

TRICARE Non-Network Physician/Dentist Individual Application

First Name: _____ MI: ____ Last Name: _____

Gen: _____ Title: _____

Social Security #: _____ NPI#: _____

Physical Address (Street Address): Billing or Mailing Address (If Different):

_____ _____

_____ _____

_____ _____

Telephone #: _____ Billing Telephone #: _____

Fax #: _____ Billing Fax #: _____

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

Do you maintain a solo practice? ____ Yes ____ No

If yes, Tax ID # of solo practice: _____

NPI#: _____

Date you began using this Tax ID #: _____

Do you work with an established group practice or institution? ____ Yes ____ No

If yes, practice name: _____

Practice Tax ID #: _____

NPI#: _____

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

_____

Date you began practicing with this group number: _____

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 North Region Provider Data Management
Non-Network Provider Application Packet
Provider Certification

To certify you as a **Physician/Dentist**, please provide the following information to confirm you meet TRICARE requirements. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. Failure to provide complete and accurate information will negatively impact claims payment.

Licensure:

License Number: _____

Original License Issue Date: _____ Current Expiration Date: _____

Are you:

Employed by the US Government ____ Yes ____ No

Resident ____ Yes ____ No

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

_____

By signing below, I attest to meeting the above TRICARE requirements. I understand that federal laws 18 U.S.C. 287 and 1001 provide for 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.

Practitioner Signature: _____ 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 _____

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 _____