



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](http://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](http://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: \_\_\_\_\_ 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 \_\_\_\_\_ COUNTY OF \_\_\_\_\_

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 \_\_\_\_\_ STATE OF \_\_\_\_\_

(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 \_\_\_\_\_ COUNTY OF \_\_\_\_\_

\_\_\_\_\_ 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 \_\_\_\_\_ STATE OF \_\_\_\_\_

(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. 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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## EFT ENROLLMENT

Dear Provider:

Thank you for your interest in Electronic Funds Transfer (EFT) with PGBA, LLC. Please take a moment to review the enrollment guidelines (Appendix A). Once you have reviewed the guidelines, please complete the enclosed enrollment form (Pages 2a & 3a) with all required information, along with the Terms and Conditions located on page 4a.

In addition to EFT, PGBA, LLC. also offers Electronic Remittance Advice (ERA) which requires a separate enrollment form. If you choose both transactions, you will need to contact your financial institution to arrange for the delivery of the CORE-required minimum CCD+ data elements necessary for successful reassociation of the EFT payment with the ERA remittance advice.

To help expedite the process, you may enroll online at [www.myTRICARE.com](http://www.myTRICARE.com). In order to enroll online, you must have a myTRICARE secure account. If you already have a myTRICARE secure account, please first log in, if you have not done so already. If you are not a registered myTRICARE secure account holder, please go to [www.myTRICARE.com](http://www.myTRICARE.com) and register.

If you do not wish to enroll online, please fax your completed forms to:

PGBA, LLC  
TRICARE Electronic Data Interchange  
FAX: 803-462-3995

**Please retain a copy of the completed enrollment form for your records.**

Online instructions for checking the status of EFT enrollment can be found at [www.myTRICARE.com](http://www.myTRICARE.com)

If you do not choose to receive an 835 file or paper remittance, you have the option of viewing your remittance online at [www.myTRICARE.com](http://www.myTRICARE.com). For assistance with signing up to view remits online, contact myTRICARE support at 1-866-698-7422.

Please note, if you are not a TRICARE authorized provider, or an incomplete form is submitted, the enrollment form will be returned to the provider with a letter stating the reason for return

Please allow 4 weeks for the enrollment process which includes pre-note verification. If after 4 weeks you do not start receiving EFT payments, contact South Region Customer Service at 1-800-403-3950.

Once enrolled, EFT payments that have not been received after 4 business days of receipt of the corresponding ERA, online, or paper remittance can be researched by calling South Region Customer Service.

We are committed to making your transition to EFT as smooth as possible. If you have any questions regarding the information contained in this package, please contact the Provider Data Management Department by fax to 1-803-462-3995, or call the South Region Customer Service at 1-800-403-3950.



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## EFT ENROLLMENT FORM

Provider Information					
Provider Name					
Provider Address					
Street					
City		State		ZIP Code/ Postal Code	
Provider Identifiers Information					
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)					
National Provider Identifier (NPI)					

☐

**NOTE:** Checking this box indicates listing **all** locations for payment with a different physical address that are to be transmitted to the Financial Institution Transit/Routing and Account number listed above. Otherwise, if only **specific** locations are to be included, list them below. **Attach additional sheets if necessary.**

TRICARE Provider Number (with suffix)	National Provider Identifier (NPI)	Business Name and Address





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Provider Contact Information					
Provider Contact Name					
Telephone Number					
Email Address					
Fax Number					
Financial Institution Information					
Financial Institution Name					
Financial Institution Address					
City		State		ZIP Code/ Postal Code	
Financial Institution Routing Number					
Type of Account at Financial Institution (check one)			<input type="checkbox"/> Savings <input type="checkbox"/> Checking		
Provider's Account Number with Financial Institution					
Account Number Linkage to Provider Identifier (Must match ERA Preference)					
Provider Tax Identification Number (TIN) or National Provider Number (NPI)					
Reason for Submission			<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Enrollment <input type="checkbox"/> Cancel Enrollment		
Authorized Signature					
Signature of Person Submitting Enrollment					
Printed Title of Person Submitting Enrollment					
Submission Date		Requested EFT Start/Change/Cancel Date			



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## TERMS AND CONDITIONS FOR ELECTRONIC FUNDS TRANSFER

By Signing below your company agrees to accept payment by PGBA, LLC (PGBA) through electronic funds transfer (EFT). Additionally, you acknowledge and agree that all payments shall be made in accordance with the information that you supply on the Electronic Funds Transfer Authorization Form and that PGBA shall be entitled to rely exclusively upon such information. This agreement applies to and amends all existing agreements with PGBA by incorporating the following terms and conditions for electronic payment.

PGBA will initiate payment to you based on the following:

1. PGBA will transfer funds electronically to the financial institution and account number you register on the attached EFT/ERA Enrollment Form.
2. PGBA will make payments in accordance with and be governed by the National Automated Clearinghouse Association's Corporation Trade Payment Rules. Our process is governed by and in accordance with the laws, other than choice of law provision of any particular contract, of South Carolina, including Article 4A of the Uniform Commercial Code as enacted by South Carolina and amended from time to time.
3. The information you provide on the EFT/ERA Enrollment Form is very important. PGBA shall not be liable for any loss which may arise solely by reason of error, mistake, or fraud regarding this information. You understand that you must communicate any change in this information to PGBA. This communication must be in the form of a new EFT ERA Enrollment Form faxed to this number:

**PGBA, LLC EFT**  
**Fax: 1 803-462-3995**

4. Payment is initiated within the normal terms of our agreement with you and/or applicable TRICARE procedures. Our EFT terms and conditions neither enlarge nor diminish the parties' respective rights and obligations within any applicable agreement. The payment due date is not affected. We will consider payment made when your financial institution has received or has control of the payment transaction. This will generally occur within three (3) calendar days following initiation by PGBA. If payment is initiated on a non-banking day at PGBA's originating bank, the funds transfer will occur the following banking day. In all cases, "Banking Day" is defined as the day on which both trading partners' banks are available to transmit and receive these fund transfers.
5. With respect to the EFT reimbursement process, PGBA is responsible up to the point where your financial institution receives or has control of the transaction. Any loss of data at that point will be borne by you unless the loss is due solely to the negligence of PGBA or its originating bank.

You hereby represent that you are authorized to enter into this agreement, disburse funds, sign checks, and modify account information for the provider locations listed below.

NAME: \_\_\_\_\_  
(Please Print)

SIGNATURE: \_\_\_\_\_

TITLE: \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_



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## APPENDIX A

# TRICARE SOUTH EFT ENROLLMENT Form Completion Guidelines

### **Instructions for completing the EFT Enrollment form**

- Please type or print legibly.
- Use only black or blue ink to complete paper form.
- Online form can be accessed at [www.myTRICARE.com](http://www.myTRICARE.com)
- Please allow 4 weeks for enrollment process. If after 4 weeks you do not start receiving EFT payments, you may contact PDM Support at 1-800-403-3950 or go to [www.myTRICARE.com](http://www.myTRICARE.com) for other contact information.

### **Provider Information**

- **Provider Name** - Complete legal name of institution, corporate entity, practice or individual provider.
- **Provider Address**- associated with the institution, corporate entity, practice or individual provider.
- **Street** - The number and street name where a person or organization can be found.
- **City**- City associated with provider address field.
- **State/Province** - ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.
- **ZIP Code/Postal Code** - System of postal zone codes (ZIP stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery) and exploit electronic reading and sorting capabilities.

### **Provider Identifiers**

- **Provider Federal Tax Identification Number (TIN)** - A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.
- **National Provider Identifier (NPI)** - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.



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#### **Provider Contact Information**

- **Provider Contact Name** - Name of a contact in provider office for handling EFT issues.
- **Telephone Number** - Associated with contact person.
- **Email Address** - An electronic mail address at which the health plan might contact the provider.
- **Fax Number** - A number at which the provider can be sent facsimiles.

#### **Financial Institution Information**

- **Financial Institution Name** - Official name of the provider's financial institution.
- **Financial Institution Routing Number** - A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.
- **Type of Account at Financial Institution** - The type of account the provider will use to receive EFT payments. e.g., Checking, Savings.
- **Provider Account Number with Financial Institution** - Provider's account number at the financial institution to which EFT payments are to be deposited.
- **Account Number Linkage to Provider Identifier** - Provider preference for grouping (bulking) claim payments- must match preference for V5010 X12 835 remittance advice

Must fill out one of the two options below:

- **Providers Tax Identification Number (TIN)** - as described in "Provider Identifiers".
- **National Provider Identifier (NPI)** - as described in "Provider Identifiers".

#### **Reason for Submission** - Must select one from below

- **New Enrollment** - indicating new enrollment.
- **Change Enrollment** - write a note stating the needed change and the requested ERA effective date of the change.
- **Cancel Enrollment** - provide requested ERA effective date of the cancellation.

**Authorized Signature** - The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment may be used with electronic and paper-based manual enrollment.

- **Signature of Person Submitting Enrollment** - A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.
- **Printed Name of Person Submitting Enrollment** - The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
- **Printed Title of Person Submitting Enrollment** - The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment.
- **Submission Date** - The date on which the enrollment is submitted.
- **Requested EFT Start/Change/Cancel Date** - The date on which the requested action is to begin.



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## ERA ENROLLMENT

Dear Provider:

Thank you for your interest in Electronic Remittance Advice (ERA) with PGBA, LLC. Please take a moment to review the enrollment guidelines (Appendix B). Once you have reviewed the guidelines, please complete the enclosed enrollment form (Pages 2b & 3b) with all required information.

In addition to ERA, PGBA, LLC also offers Electronic Funds Transfer (EFT), which requires a separate enrollment form. If you choose both transactions, you will need to contact your financial institution to arrange for the delivery of the CORE-required minimum CCD+ data elements necessary for successful reassociation of the EFT payment with the ERA remittance advice.

To help expedite the process, you may enroll online at [www.myTRICARE.com](http://www.myTRICARE.com). In order to enroll online, you must have a myTRICARE secure account. If you already have a myTRICARE secure account, please first log in, if you have not done so already. If you are not a registered myTRICARE secure account holder, please go to [www.myTRICARE.com](http://www.myTRICARE.com) and register.

If you do not wish to enroll online, please fax or mail your completed forms to:

FAX: 803-264-9864  
PGBA, LLC  
TRICARE Electronic Data Interchange  
PO BOX 17150  
Augusta, GA 30903

**Please retain a copy of the completed enrollment form for your records.**

Online instructions for checking the status of ERA enrollment can be found at [www.myTRICARE.com](http://www.myTRICARE.com).

Please note, if you are not a TRICARE authorized provider, or an incomplete form is submitted, the enrollment form will be returned to the provider with a letter stating the reason for return.

Please allow 4 weeks for the enrollment process to be completed. If after 4 weeks you do not start receiving ERA files, you may contact the EDI Help Desk at 1-800-325-5920, Option #2 or by Email at [EDI.TRICARE@PGBA.com](mailto:EDI.TRICARE@PGBA.com).

Once enrolled, ERA files that have not been received after 4 business days of receipt of the corresponding EFT file or check payment can be researched by calling or Emailing the EDI Help Desk.

We are committed to making your transition to ERA as smooth as possible. Arrangements can be made for you to receive a paper copy of your remit in conjunction with an 835 transaction file for up to 31 days by contacting the EDI Help Desk.

If you have any questions regarding the information contained in this package, please contact our EDI Help Desk at 1-800-325-5920, Option #2 or by Email to [EDI.TRICARE@PGBA.com](mailto:EDI.TRICARE@PGBA.com).



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## ERA ENROLLMENT FORM

PROVIDER INFORMATION					
Provider Name					
PROVIDER ADDRESS					
Street					
City		State		ZIP Code/ Postal Code	
PROVIDER IDENTIFIERS INFORMATION					
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)					
National Provider Identifier (NPI)					
Other identifier(s)	Trading Partner ID			7GW _ _ _ _ _	
<input type="checkbox"/> <b>NOTE:</b> Checking this box indicates enrolling <u>all</u> locations for this provider's TIN/EIN that are active in our provider files and will no longer receive a paper remit. Otherwise, if only <u>specific</u> locations are to be included, list them below. <b>Attach additional sheets if necessary.</b>					
TRICARE Provider Number (with suffix)	National Provider Identifier (NPI)		Business Name and Address		
PROVIDER CONTACT INFORMATION					
Provider Contact Name					
Telephone Number					



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Physician  
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Email Address			
Fax Number			
<b>ELECTRONIC REMITTANCE ADVICE INFORMATION (See instructions)</b>			
<i>Preference for Aggregation of Remittance Data          (e.g. Account Number Linkage to Provider Identifier)</i>		<i>Provider preference for grouping (bulking) claim payment advice – must match preference for EFT payment</i> <b>Select TIN or NPI and enter below:</b>	
Provider Tax Identification Number (TIN) or National Provider Number (NPI)			
Method of Retrieval			
<b>ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION</b>			
Clearinghouse Name			
Telephone Number			
Email Address			
<b>SUBMISSION INFORMATION</b>			
Reason for Submission		<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Enrollment <input type="checkbox"/> Cancel Enrollment	
<b>Authorized Signature</b>			
Written Signature of Person Submitting Enrollment			
Printed Title of Person Submitting Enrollment			
Submission Date		Requested ERA Effective Date	



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## APPENDIX B

# TRICARE SOUTH ERA ENROLLMENT Form Completion Guidelines

### **Instructions for completing the ERA Enrollment form**

- Please type or print legibly.
- Use only black or blue ink to complete paper form.
- Online form can be accessed at [www.myTRICARE.com](http://www.myTRICARE.com)

### **Provider Information**

- **Provider Name** - Complete legal name of institution, corporate entity, practice or individual provider.
- **Provider Address**- Associated with institution, corporate entity, practice, or individual provider.
- **Street** - The number and street name where a person or organization can be found.
- **City**- City associated with provider address field.
- **State/Province** - ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.
- **ZIP Code/Postal Code** - System of postal zone codes (ZIP stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery) and exploit electronic reading and sorting capabilities.

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### **Other Identifiers**

- **Assigning Authority** - Organization that issues and assigns the additional identifier requested on the form.
- **Trading Partner ID** - The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor.





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[www.myTRICARE.com](http://www.myTRICARE.com) by PGBA

Physician  
Provider Application Package

### **Provider Contact Information**

- **Provider Contact Name** - Name of a contact in provider office for handling EFT issues.
  - **Telephone Number** - Associated with contact person.
  - **Email Address** - An electronic mail address at which the health plan might contact the provider.
  - **Fax Number** - A number at which the provider can be sent facsimiles.
  - **Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)** - Provider preference for grouping (bulking) claim payments - must match preference for EFT payment.
- Must fill out one of the two options below:
- **Providers Tax Identification Number (TIN)** - as explained in "Provider Identifiers".
  - **National Provider Identifier (NPI)** - as explained in "Provider Identifiers".
- **Method of retrieval** - Electronic remits can be retrieved in a HIPAA 835 file format directly or through a clearinghouse. Provider remits can also be viewed/downloaded from the myTricare web site if you are a member. Once set up for either method, paper remits will be stopped.

### **Clearinghouse Information**

- **Clearinghouse Name** - Official name of the provider's clearinghouse.
- **Telephone Number** - Telephone number of contact.
- **Email Address** - An electronic mail address at which the health plan might contact the provider's clearinghouse.

### **Reason for Submission:** Must select one from below

- **New Enrollment** - indicating new enrollment.
- **Change Enrollment** - write a note stating the needed change and the requested ERA effective date of the change.
- **Cancel Enrollment** - provide requested ERA effective date of the cancellation.

**Authorized Signature** - The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment may be used with electronic and paper-based manual enrollment.

- **Signature of Person Submitting Enrollment** - A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.
- **Printed Name of Person Submitting Enrollment** - The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
- **Printed Title of Person Submitting Enrollment** - The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment.
- **Submission Date** - The date on which the enrollment is submitted.
- **Requested ERA Effective Date** - Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner.