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 Assistant
Provider Application Package

TRICARE®
PHYSICIAN ASSISTANT
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: 352-799-0046

EMAIL: CREDENTIALING@ACCESSHEALTHCARELLC.NET

Revised 11/4/14

Humana. Government Business

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Physician Assistant
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TRICARE
PHYSICIAN ASSISTANT APPLICATION

NAME: _____

SOCIAL SECURITY NUMBER: _____ NPI#: _____

Are you employed by the U.S. Government? ☐ YES ☒ NO

OFFICE LOCATION (Street Address):

_____

_____

_____

Office Tele. No: (____) ____-_____ ext. _____

BILLING ADDRESS (If different):

PO BOX 919469

ORLANDO, FL 32891-9469

_____

Billing Tele. No: (____) ____-_____ ext. _____

YOUR EMPLOYING PHYSICIAN MUST BE AN AUTHORIZED TRICARE PROVIDER AND A COMPLETED GROUP APPLICATION MUST BE ON FILE WITH PGBA, LLC.

Name of Employing Physician or Group: Access HealthCare Physician L EIN: 452 444 883

Telephone: (____) ____-_____ ext. _____ Date you joined group: ___/___/_____

I will be signing my own claim forms: ☐ YES ☒ NO

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TRICARE
PHYSICIAN ASSISTANT APPLICATION

IF STATE LICENSURE IS AVAILABLE IN YOUR STATE OF PRACTICE, IT IS REQUIRED EVEN IF THE STATE OFFERS LICENSURE ON A VOLUNTARY BASIS.

License No.: _____ Issuing State: Florida _____

NPI: _____ Original License Date: ___/___/_____

Current License Effective Dates: From ___/___/_____ To ___/___/_____

ATTACH A PHOTOCOPY OF YOUR LICENSE.

I certify that I meet the applicable state requirements governing qualifications for physician assistants and at least one of the following:

☐ I am currently certified by the National Commission on Certification of Physician Assistants to to assist primary care physicians, OR
(ATTACH COPY OF CERTIFICATION EFFECTIVE DATE: ___/___/_____)

☐ I have satisfactorily completed a program for preparing physician assistants that:
A. Was at least one academic year in length; and
B. Consisted of supervised clinical practice and at least four months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and
C. Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; OR
(ATTACH PROOF OF COMPLETION EFFECTIVE DATE: ___/___/_____)

☐ I have satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of paragraph 2 of this section and had been assisting primary care physicians for a minimum of twelve months during the 18-month period immediately preceding January 1, 1987.
(ATTACH COPY OF CERTIFICATION EFFECTIVE DATE: ___/___/_____)

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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 Dr. Pariksith Singh MD (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 ACCESS HEALTHCARE PHYSICIANS LLC
(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

451 444 883
_____ _____
Employer Identification Number Social Security Number

124 552 9742
_____ _____
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.