



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

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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: _____ PHONE: _____

EMAIL: _____

Revised 11/4/14



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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): BILLING ADDRESS (If different):

_____	_____
_____	_____
_____	_____

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

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: _____

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 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 _____ 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.