



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.