



**TRICARE  
CLINICAL SOCIAL WORKER  
PROVIDER APPLICATION**

**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 Individual Social Worker 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.

To certify you as a **Clinical Social Worker (CSW)** 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:** *licensed or certified as a CSW by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of CSWs, is certified by a national professional organization offering certification of CSWs*

License/Certification Number: \_\_\_\_\_

Original License/Certification Date: \_\_\_\_\_ Current Expiration Date: \_\_\_\_\_

**Education:** *Has at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education*

Date Graduated: \_\_\_\_\_ Degree Earned: \_\_\_\_\_

Name of University: \_\_\_\_\_

**Clinical Experience:** *Has completed a minimum of two years or three thousand hours of post-Master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting*

\_\_\_\_ Yes \_\_\_\_ No      Date Experience Requirements Met: \_\_\_\_\_

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: \_\_\_\_\_

TRICARE North Region Provider Data Management  
Fax 1-888-279-3540  
P.O. Box 870156 Surfside Beach, SC 29587-9756  
www.myTRICARE.com by PGBA

Revised: 3/31/2016

**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 \_\_\_\_\_



A CELERIAN GROUP COMPANY

## PGBA, LLC

TRICARE North EFT  
PO Box 870154  
Surfside Beach, SC 29587-9754  
FAX 1-888-536-2324

### Electronic Funds Transfer (EFT) Authorization Agreement

Please complete all fields on pages 1 and 2 of this form. Form Completion Guidelines and Terms and Conditions can be found on pages 2 and 3. Mail or fax the completed form along with required documentation to the address or fax number noted above. Please retain a copy of the completed EFT Authorization Agreement for your records.

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) - required when provider has been enumerated with an NPI:				
	NOTE: Checking this box indicates payment for all locations of the above TIN to be transmitted to the Financial Institution Transit/Routing and Account number indicated on this EFT Authorization Agreement. 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:		
Provider Contact Information				
Provider Contact Name:		Telephone Number:		
Email Address:		Fax Number:		
Financial Institution Information				
Financial Institution Name:				
Financial Institution Routing Number:				
Type of Account at Financial Institution (check one):		Savings	Checking	
Provider's Account Number with Financial Institution:				
Account Number Linkage to provider Identifier (Must match ERA Preference) Check one:	Provider Tax Identification Number (TIN)		National Provider Identification Number (NPI)	
Note: If enrolled for 835 Electronic Remittance Advice (ERA), the provider must contact their financial institution to arrange for the delivery of the CORE-required minimum CCD+ data elements needed for association of the payment and the 835 ERA.				



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For assistance, contact our EDI Help Desk  
1-877-334-2524 (1-877-EDI-CLAIM)  
[www.myTRICARE.com](http://www.myTRICARE.com) by PGBA

Submission Information			
Reason for Submission:	New Enrollment	Change Enrollment	Cancel Enrollment
Include with Enrollment Submission:	Voided Check	Bank Letter	
Written Signature of Person Submitting Enrollment:			
Printed name of Person Submitting Enrollment:			
Printed Title of Person Submitting Enrollment:			
Submission Date:		Request EFT Start/Change/Cancel Date:	

## Form Completion Guidelines

- Please type or print legibly using blue or black ink.
- 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 are not a registered myTRICARE Secure account holder, please go to [www.myTRICARE.com](http://www.myTRICARE.com) to register.
- Please allow up to 4 weeks for the enrollment process which includes pre-note verification.
- Online instructions for checking the status of EFT payments can be found at [www.myTRICARE.com](http://www.myTRICARE.com).
- 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 TRICARE North Region Customer Service at 1-877-874-2273.
- If you have any questions regarding the information contained in the EFT Authorization Agreement, please contact the TRICARE North EDI Help Desk at 1-877-334-2524.
- Mail or fax the completed form along with required documentation to:

PGBA, LLC  
TRICARE North EFT  
PO Box 870154  
Surfside Beach, SC 29587-9751

Fax: 1-888-536-2324

Provider Information	
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider.
Provider Address	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 deposited.
Type of Account at Financial Institution	The type of account the provider will used 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 select one of the following: Provider's Tax Identification Number (TIN) or National Provider Identifier (NPI).
Submission Information	
Reason for Submission	New Enrollment, Change Enrollment, Cancel Enrollment
Include with Submission	Voided Check - A voided check is attached to provide confirmation of Identification/Account Numbers.
	Bank Letter - A letter on bank letterhead that formally certifies the account owners routing and account numbers.
Written 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 enrolment.
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.

### TERMS AND CONDITIONS FOR ELECTRONIC FUNDS TRANSFER

By completing and submitting this form, 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 Agreement 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 this EFT Authorization Agreement.
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 Authorization Agreement 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 Authorization agreement faxed to this number: **1-888-536-2324**
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 nonbanking 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 in this EFT Authorization Agreement.