# TRICARE NON-NETWORK PHYSICIAN ASSISTANT PROVIDER APPLICATION

*We expect providers to submit claims electronically. If it is necessary to submit a paper claim, the only acceptable forms are the approved **red and white** NUCC 1500 (02-12) form and the NUBC UB-04 (CMS -1450) forms. These forms must include the instructions on the back page.*

**Please submit the completed application package to:**

**Fax: 877-989-0066**

**or**

**Mail to:**

**TRICARE West**

**Provider Data Management**

**PO Box 202169**

**Florence, SC 29502-2169**

*TriWest Healthcare Alliance offers payments and remittances by National Provider Identifier (NPI) number. **The NPI billed on the claim will determine where payment and remittance will be sent.** It is critical the information provided matches how your office will file claims. Inconsistent data will negatively impact claims payment.*

*If your business requires multiple mailing/payment addresses, please provide an NPI for each. **If you have more than one NPI, you must complete a separate application for each NPI number.***

# TRICARE Non-Network Physician Assistant Application

First Name: _____ MI: ____ Last Name: _____

Gen: _____ Title: _____

Social Security #: _____ NPI#: _____

Are you employed by the US Government? ____ Yes ____ No

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.

Supervising Physician: _____

Tax ID#: _____ NPI: _____

## Group Practice Information

If you practice at multiple locations, please provide the information below for each location.

Group Practice Name: _____

Group Practice Tax ID #: _____ NPI#: _____

Effective date of the group's Tax ID number or EIN (Date legal entity established): _____
(mm/dd/yyyy)

Date you began practicing with this group number: _____
(mm/dd/yyyy)

| Group Physical Address (Street Address): | Group Billing Address for this NPI: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| Telephone #: _____ | Billing Telephone #: _____ |
| Fax #: _____ | Email: _____ |

Revised: 1/7/2025

To certify you as a **Physician Assistant (PA),** please provide the following information to confirm you meet TRICARE requirements. PGBA, LLC must have complete provider documentation on file to determine provider eligibility. To confirm you meet requirements, the information provided must be legible, specific and match the criteria listed. Failure to provide complete and accurate information will negatively impact claims payment.

## Licensure:

License Number: _____

Original License Issue Date: _____ Expiration Date: _____

**Certification:** *is certified by the National Commission on Certification of the Physician Assistant to assist primary care physicians*

____ Yes ____ No

Certification Number: _____

Original Issue Date: _____ Expiration Date: _____
(mm/dd/yyyy) (mm/dd/yyyy)

**Or if not nationally certified**: has 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 healthcare; and
c. Was accredited by the American Medical Association's committee on Allied Health Education and Accreditation.

____ Yes ____ No Date completed: _____
(mm/yyyy)

**A Physician Assistant (PA) may provide covered services under general supervision of a physician. Physician supervision may be remote and does not require direct contact between the physician and physician assistant at the time the care is rendered. The employing physician must be immediately available to the physician assistant (PA) for consultation purposes by telephone.*

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: _____

## PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

State of _____

County of _____

_____ being first duly sworn, deposes and says: I hereby authorize PGBA, LLC / TriWest Healthcare Alliance 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 _____