TRICARE NON-NETWORK
AUTISM CARE DEMONSTRATION (ACD)
BOARD CERTIFIED BEHAVIOR ANALYST (BCBA/BCBA-D)
and LICENSED BEHAVIOR ANALYST (LBA)
PROVIDER APPLICATION

Please submit the completed application package to:

Fax: 877-989-0066

or

Mail to:

TRICARE West
Provider Data ManagementPO 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 Autism Care Demonstration (ACD)
(BCBA, BCBA-D and LBA) Individual 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.

Do you maintain a solo practice? ____ Yes ____ No

Solo Practice Information

Solo Practice Tax ID: _____ NPI#: _____

Date you began using this Tax ID #: (mm/dd/yyyy) _____

Solo Physical Address (Street Address): Solo Billing Address for this NPI:

_____ _____

_____ _____

_____ _____

Telephone #: _____ Billing Telephone #: _____

Fax #: _____ Email: _____

Do you work with an established group practice or institution? ____ Yes ____ No

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 #: _____

Revised: 1/7/2025

Fax #: _____ Email: _____

To certify you as a **Board Certified Behavior Analyst (BCBA/BCBA-D) or Licensed Behavior Analyst (LBA),** 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.

1. **Attach a copy of your Master's or Doctoral Degree.**

   Date Graduated: _____ Degree Earned: _____
   (mm/yyyy)

   Name of University: _____

2. **Are you state licensed or state certified to provide ABA services?** ____ Yes ____ No

   License Number: _____

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

   *Attach a copy of State license or certification

3. **If state does not offer Licensure, are you certified by the Behavioral Analyst Certification Board (BACB)?** ____ Yes ____ No

   BACB Certification Number: _____

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

   *Attach copy of BACB certification.

4. Must have completed the training for Basic Life Support (BLS) or a Cardiopulmonary Resuscitation (CPR) equivalent certification, as demonstrated by completion of a hybrid course comprised of a web-based instruction component and live component to demonstrate skills on a dummy. Any course that is done entirely in person is also acceptable.

   Date Completed: _____
   (mm/dd/yyyy)

*Attach copy of certification

5. **Attach a copy of your professional liability insurance in the amounts of one million dollars per claim and three million dollars in aggregate.**

6. **The Participation Agreement and Background Check Form needs to be completed, signed and returned with the application.**

TRICARE Non-Network Participation Agreement for Autism Care Demonstration (ACD) (BCBA/BCBA-D/LBA) Sole Provider Practice

Name of Sole Provider: _____

Office Address: _____

_____

Telephone: _____

Tax ID Number: _____

NPI Number: _____

ARTICLE 1

RECITALS

1.1 IDENTIFICATION OF PARTIES

This Comprehensive Autism Care Demonstration Sole Provider Participation Agreement ("Participation Agreement") is between the United States of America (USA) through the Defense Health Agency (DHA), an agency of the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) and _____, doing business as _____ (hereinafter "Sole Provider").

1.2 AUTHORITY FOR SOLE PROVIDERS AS TRICARE-AUTHORIZED PROVIDERS

The authority to designate Sole Providers as authorized TRICARE providers resides with the Department of Defense (DoD) Demonstration authority under 10 USC 1092. This authority ceases upon termination of the Comprehensive Autism Care Demonstration Project ("Demonstration") as determined by the Director, DHA, or designee.

1.3 PURPOSE OF PARTICIPATION AGREEMENT

The purpose of this Participation Agreement is to:

(a) Establish the undersigned Sole Provider as an authorized provider of Applied Behavior Analysis (ABA) services;

(b) Establish the terms and conditions that the undersigned Sole Provider must meet to be an authorized provider under the Demonstration.

ARTICLE 2

REFERENCES

2.1 REQUIREMENTS

By reference, the requirements set forth in the TRICARE Operations Manual (TOM), Chapter 18, Section 3, are incorporated into this Participation Agreement and shall have the same force and effect as if fully set out herein. In addition, the provider must:

(a) Attend an annual provider education provided by the TRICARE Managed Care Support Contractors (MCSCs), Uniformed Services Family Health Plans (USFHP) Designated Providers (DPs), or the TRICARE overseas contractor.

(b) Incorporate discharge summaries and planning into every treatment plan. The provider cannot abruptly stop/terminate services for any reason to a beneficiary. All discharges or cessation of services require a minimum of a 30 calendar day transition/discharge plan.

(c) If the Sole Provider terminates services with any beneficiary for any reason, the Sole Provider must notify the contractor a minimum of 45 calendar days prior to termination.

2.2 GENERAL AGREEMENT

(a) The undersigned Sole Provider agrees to render clinically appropriate ABA services to eligible beneficiaries as specified in the TOM, Chapter 18, Section 3.

(b) Comply with all applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/copayment may be expected.

(c) Signing of this Participation Agreement attests that the Sole Provider has reviewed and agrees to comply with the requirements set forth in TOM, Chapter 18, Section 3.

ARTICLE 3

REIMBURSEMENT

3.1 Claims for Demonstration services will be submitted electronically on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form by the Sole Provider in accordance with the TOM, Chapter 18, Section 4.

3.2 The Sole Provider shall:

(a) Submit claims to the appropriate TRICARE contractor, USFHP DP, or TRICARE overseas contractor in accordance with the TOM, Chapter 18, Section 3; and

(b) Collect the sponsor cost-share in accordance with TOM, Chapter 18, Section 3; and

(c) Not bill the sponsor/beneficiary for:

(1) Services for which the provider is entitled to TRICARE reimbursement; and

(2) Services not clinically necessary and appropriate for the clinical management of the presenting illness, injury, or disorder;

(3) Services for which a provider would be entitled to payment but for a reduction or denial in payment as a result of quality review; and

(4) Services that are denied or recouped due to provider non-compliance with all applicable requirements in the TOM, Chapter 18, Section 3.

3.3 All claims for Demonstration services will be paid by electronic funds transfer.

ARTICLE 4

RECORDS AND AUDIT PROVISIONS

4.1 The Sole Provider grants the Director, DHA [or authorized representative(s)], the right to conduct on-site or off-site reviews or audits with full access to patients and records. The audits will be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit/ review includes, but is not limited to, the right to:

(a) Examine fiscal and all other records of the Sole Provider which would confirm compliance with this agreement and designation as an authorized Sole Provider under the ACD.

(b) Conduct audits of Sole Provider records including administrative and clinical records to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided to beneficiaries. The Director, DHA, or a designee shall have full access to records of TRICARE beneficiaries.

4.2 RECORDS REQUESTED BY DHA

Upon request, the Sole Provider shall furnish DHA or a designee such records, including administrative and medical records, that would allow DHA or a designee to determine the quality and cost-effectiveness of care rendered.

4.3 FAILURE TO COMPLY

Failure to allow audits/reviews and/or to provide records constitutes a material breach of this agreement. It may result in denial or reduction of payment, termination of this agreement pursuant to Article 5, and any other appropriate action by DHA.

ARTICLE 5

TERM, TERMINATION, AND AMENDMENT

5.1 TERM

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated or superseded as specified herein.

5.2 TERMINATION OF AGREEMENT BY DHA

(a) The Director, DHA, or designee, may terminate this agreement upon written notice, for cause, if the Sole Provider is found not to be in compliance with the provisions set forth in TOM, Chapter 18, Section 3, or is determined to be subject to the administrative remedies involving fraud, abuse, or conflict of interest as set forth in 32 CFR 199.9. Such written notice of termination shall be an initial determination for purposes of the appeal procedures set forth in 32 CFR 199.10.

(b) In addition, the Director, DHA, or designee, may terminated this agreement without cause by giving the Sole Provider written notice not less than 45 calendar days prior to the effective date of such termination.

5.3 TERMINATION OF AGREEMENT BY THE SOLE PROVIDER

The Sole Provider may terminate this agreement by giving the Director, DHA, or designee, written notice not less than 45 calendar days prior to the effective date of such termination. Effective the date of termination, the Sole Provider will cease being a TRICARE-authorized provider of Demonstration services. Subsequent to termination, a Sole Provider may be reinstated as a TRICARE-authorized provider of Demonstration services only by entering into a new Participation Agreement.

5.4 AMENDMENT BY DHA

(a) The Director, DHA, or designee, may amend the terms of this Participation Agreement by giving 120 calendar days notice in writing of the proposed amendment(s) except when necessary to amend this agreement from time to time to incorporate changes to the TOM, Chapter 18, Section 3 and 32 CRF 199. When changes or modifications to this agreement result from changes to the 32 CFR 199 through rulemaking procedures, the Director, DHA, or designee, is not required to give 120 calendar days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective.

(b) A Sole Provider who does not accept the proposed amendment(s), including any amendment resulting from changes to TOM, Chapter 18, Section 3 and 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the Sole Provider notice of intent to terminate its participation is not given at least 30 calendar days prior to the effective date of the proposed amendment(s), the proposed amendment(s) shall be incorporated into this agreement for services furnished by the Sole Provider between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 6

EFFECTIVE DATE

6.1 DATE SIGNED

This Participation Agreement is effective on the date signed by the Director, DHA, or designee.

DHA: Sole Provider:

_____ _____

By: Signed Name and Title By: Signed Name and Title

Executed on _____, 20____

_____ _____

(TIN) (NPI)

ALL PRACTITIONERS
STATEMENT OF RELEASE AND UNDERSTANDING

I hereby certify that the information provided in this application is true and accurate and reflects my current level of training, experience, and demonstrated competence to practice with the clinical privileges I have requested. I understand that I have the burden and legal responsibility of providing true and adequate information to demonstrate my professional competence, character, moral ethics, and other qualifications. I further understand that any significant misstatement or omission on this application may constitute cause for denial of participation or dismissal from TriWest Healthcare Alliance or be subject to applicable state or federal penalties for perjury.

I agree to authorize TriWest Healthcare Alliance, its representatives or agents to conduct a criminal history records check and to consult with and inspect all documents from individuals and organizations having information bearing on my qualifications, including present and past professional liability insurance carrier(s), including information concerning any restriction on my clinical privilege coverage and any information concerning those cases which have been settled, lost, received judgment or are pending. I further consent to the release of information concerning any professional misconduct proceeding, and any malpractice actions involving me in any state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions, and to the fullest extent permitted by law, release practitioners of such information from any and all liability.

I further authorize the copy of my signature on this document, as part of the application, to be as binding as the original. I agree that TriWest Healthcare Alliance, its representatives and individuals or entities providing information to TriWest Healthcare Alliance in good faith shall not be liable for any act or occasion related to the evaluation or verification contained in this document, which is part of the application. I further agree to notify TriWest Healthcare Alliance in a timely manner of any change to the information requested in this application. Information requested in this application that is not publicly available will be treated as confidential by TriWest Healthcare Alliance.

I declare under penalty of perjury that my license(s) is/are in good standing. I agree to notify TriWest Healthcare Alliance within ten (10) days of any change to the status of my license, or any investigation into my licensure.

Applicant Name (please print): _____

Please go to second page of document for signature line.

Applicant Social Security Number*: _____
*(*A social security number is required to conduct a background check)*

Applicant Date of Birth*: _____
*(*Date of birth is required to conduct a background check)*

Attached you will find a document that lists the limitation on the number of years that a state can report criminal and/or Bankruptcy cases under state law. Using the attached document, please list all states in which you have lived during the reporting period. Please include the name of the last city in which you resided in within the state. If you have been licensed in any state in which you have not lived, please indicate that state as well (Please PRINT legibly)

State	Reporting period
CA	10 years
KY	no limit
ME	10 years
MD	10 years
MA	10 years
MT	14 years
NV	10 years
NH	10 years
NM	14 years
NY	14 years
TX	10 years
WA	10 years
All Other States	7 years

I have lived in the following cities and states:
(Example: If you lived in CA 12 years ago, you do NOT need to list CA. If you have EVER lived in KY, please list KY). You need only include one city per state.

City State

_____

_____

_____

_____

_____

_____

_____

Current Address:

Street _____

City _____ State_____ Zip_____

Applicant Signature: _____

Gender: ____ Male ____ Female

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 _____

Electronic Funds Transfer (EFT) Authorization Agreement

This form authorizes PGBA, LLC to administer any payment to you as an EFT. If you have any questions regarding the information contained in the EFT Authorization Agreement, please contact **PGBA EDI Help Desk at 800-259-0264 and follow the prompts.**

Please note: ***This application will be verified with a confirmed entity before processing.***

EFT Form Instructions

- Type or print legibly using blue or black ink. Complete all fields of the form.
- For your reference, field definitions and Terms and Conditions are available at the end of the form.
- FAQs can be found at the end of the enrollment package for your immediate reference.
- Please retain a copy of the completed EFT Authorization Agreement for your records.
- **TO SUBMIT MULTIPLE NPIs ON ONE FORM**:
    - Financial Institution Information must be the same for all submitted billing NPIs.
    - In the NPI field, indicate the request is for "multiple NPIs."
    - Attach a document that contains the following information for each billing NPI:
        - Tax ID Number
        - Billing NPI
        - Physical location address
        - Provider name
        - One PGBA check number (issued within the last 60 days)

Provider Information				
Provider Name *(legal practice name, not rendering provider)*:				
Provider Address: *(physical address)*	Street:	City:	State:	ZIP:

Provider Identifiers Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):	National Provider Identifier (NPI):

Note: *Payment for all locations of the above NPI will be transmitted to the financial institution transit/routing and account number indicated on this EFT Authorization Agreement. Payments are made at the NPI level. If a specific location requires payment to a different account, it must have a different NPI <u>and</u> you must complete a separate EFT form.*

Provider Contact Information		
Provider Contact Name:		Department:
Telephone Number:	Fax Number:	Email Address:

Provider Agent Information				
Provider Agent Name:				
Agent Address:	Street:	City:	State:	ZIP:

Provider Agent Contact Name:		Title:
Telephone Number:	Fax Number:	Email Address:

Financial Institution Information		
Financial Institution Name:	Financial Institution Routing Number:	Type of Account at Financial Institution (check one): ☐ Savings OR ☐ Checking
Provider's Account Number with Financial Institution:	Account Number Linkage to Provider Identifier: *Provider payments and remittances are issued at the NPI level. Provider preference for grouping (bulking) claim payments must match preference for V5010 X12 835 remittance advice.*	
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.		

Submission Information		
	New PGBA Enrollment *Include **ONE (1)** PGBA check number received within the last 60 days. ***NOTE:*** *PGBA check numbers are 10-digits in length and begin with 00.*	Check number: _____
	Change PGBA Enrollment *Include previous routing & account numbers used for receiving EFT payments.	Routing number: _____ Account number: _____
	Cancel PGBA Enrollment *Include previous routing & account numbers used for receiving EFT payments.	Routing number: _____ Account number: _____
Include ONE of the following with Enrollment Submission:		☐ Voided Check ☐ Bank Letter *Bank letter must be signed & dated within the last year*
Written Signature of Person Submitting Enrollment:		
Printed Name of Person Submitting Enrollment:		
Printed Title of Person Submitting Enrollment:		
Submission Date:		Requested EFT *[Start/Change/Cancel]* Date:

EFT Enrollment Form - Definitions

Provider Information	
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider. The provider's name submitted must be for the PRACTICE, not a rendering provider.
Provider Address	The address submitted must be a PHYSICAL address.
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)	The NPI submitted must be for the PRACTICE, not a rendering provider. A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard, the NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. Providers who have subparts that conduct separate HIPAA standard transactions must have their own unique NPI. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means the numbers do not carry other information about health care 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.
Provider Contact Information	
Provider Contact Name	Name of contact in provider's 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.
Provider Agent Information	
Provider Agent Name	Name of provider's authorized agent (authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship).
Agent Address	The location where a person or organization can be found.
Provider Agent Contact Name	Name of a contact in agent 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.
Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are deposited.
Type of Account	The type of account the provider will use to receive EFT payments (i.e., checking, savings).
Provider Account Number	Provider's account number at the financial institution to which EFT payments are to be deposited.
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 has been signed and dated within the last year which formally certifies the account owners routing and account numbers.
Written Signature of Submitter	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.
Printed Name of Person Submitter	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
Printed Title of Person Submitter	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment.
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.
Reason for Submission	New Enrollment, Change Enrollment, Cancel Enrollment

Terms and Conditions for Electronic Funds Transfer

By completing and submitting this form, the individual and/or entity identified on this EFT Authorization Agreement (User) agrees to accept payment by PGBA, LLC (PGBA) through EFT. Additionally, User acknowledges and agrees that all payments shall be made in accordance with the information supplied on this Electronic Funds Transfer Authorization Agreement and that PGBA shall be entitled to rely exclusively upon such information. User acknowledges that from time to time PGBA may have a legitimate business need to obtain information to verify or authenticate User's account information. This agreement applies to and amends all existing agreements with PGBA regarding EFT 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 User registers 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. PGBA's process is governed by and in accordance with the laws, other than choice of law provision of any particular contract, of South Carolina as amended from time to time.
3. PGBA shall not be liable for any loss which may arise solely by reason of error, mistake, or fraud regarding this information. User understands that user must communicate any change in this information to PGBA. This communication must be in the form of a new EFT Authorization Agreement submitted by mail or fax.
4. Payment is initiated within the normal terms of PGBA's agreement with User and/or applicable procedures. These EFT terms and conditions neither enlarge nor diminish the parties' respective rights and obligations within any such applicable agreement. The payment due date is not affected. We will consider payment made when the financial institution listed on this EFT Authorization Agreement 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 non-banking 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 the financial institution listed on this EFT Authorization Agreement receives or has control of the transaction. Any loss of data at that point will be borne by User unless the loss is due solely to the negligence of PGBA or its originating bank.

User hereby represents that the individual submitting this EFT Authorization Agreement is authorized to enter into this agreement, disburse funds, sign checks and modify account information for the provider locations listed in this EFT Authorization Agreement.

Electronic Remittance Advice (ERA) Enrollment Form

The ERA enrollment form is required to receive remits of payments electronically. Please allow 4 weeks for the enrollment process to be completed and to begin receiving ERAs. Arrangements can also be made for you to receive a paper copy of your remit, in conjunction with an 835 transaction file, for up to 31 days by contacting the EDI Help Desk.

If you have any questions regarding ERA, please contact the **PGBA EDI Help Desk at 800-259-0264 and follow the prompts, or by email at PGBA.EDI@pgba.com.**

ERA Form Instructions

- Type or print legibly using blue or black ink. Complete all fields of this form.
- For your reference, field definitions can be found at the end of this form.
- Please retain a copy of the completed ERA Enrollment Form for your records.

Provider Information				
Provider Name:				
Provider Address:	Street:	City:	State:	ZIP/Postal Code:

Provider Identifiers Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):	National Provider Identifier (NPI):
Other Identifiers, Assigning Authority:	Trading Partner ID: 7GW

Note: *Checking this box indicates enrolling all locations for this provider's TIN/EIN that are active in our provider files and will no longer receive a paper remit. Otherwise, if only* ***specific*** *locations are to be included, list them below.* ***Attach additional sheets if necessary.***

Business Name	Business Address

Provider Contact Information		
Provider Contact Name:		
Telephone Number:	Fax Number:	Email Address:
Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) (Must match EFT Preference)		Provider Tax Identification Number (TIN) National Provider Identifier (NPI)
Method of Retrieval (*Required if provider is not using clearinghouse or vendor*):		

Electronic Remittance Advice Clearinghouse Information	
Clearinghouse Name:	
Telephone Number:	Email Address:
Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment	

Authorized Signature	
Electronic Signature of Person Submitting Enrollment:	Printed Title of Person Submitting Enrollment:
Submission Date:	Requested ERA Effective Date:

ERA Enrollment Form – Definitions

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/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, 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 standard transactions.
Other Identifiers	
Assigning Authority	Name of contact in provider's office for handling ERA issues.
Trading Partner ID	Associated with contact person.
Provider Contact Information	
Provider Contact Name	Name of contact in provider's office for handling ERA 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.
Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)	Provider preference for grouping (bulking) claim payments – must match preference for EFT payment. Must fill out one of the two options below: Providers Tax Identification Number (TIN) or National Provider Identifier (NPI)
Clearinghouse Information	
Clearinghouse Name	Official name of the provider's clearinghouse.
Telephone Number	Telephone number of contact.
Email Address	An electronic mail address at which the health plan might contact the clearinghouse.
Reason for Submission	**New Enrollment. Change Enrollment:** write a note stating the needed change and the requested ERA effective date of the change. **Cancel Enrollment:** provide requested ERA effective date of the cancellation.
Authorized Signature	
Authorized Signature	The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment may be used with electronic and paper-based manual enrollment.
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 enrollment.
Submission Date	The date on which the enrollment is submitted.
Requested EFT Start/Change/Cancel Date	Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner.