



**TRICARE NON-NETWORK
AUTISM CARE DEMONSTRATION CORPORATE SERVICE PROVIDER
(ACSP) PROVIDER APPLICATION**

Instructions for completing the application:

- Complete the group application demographic information page.
- Using the ASCP Group Member Listing, list all practitioners with their name, SSN, NPI, Specialty, and the date they joined the group.
- For each practitioner, complete the appropriate TRICARE certification requirements section. Please note, TRICARE requirements are specific to the provider type and complete information is required to ensure each practitioner meets TRICARE requirements. Failure to provide complete information will negatively impact claims payment.
- ACSP providers must enter into the enclosed participation agreement.

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 Application
Autism Care Demonstration Corporate Service Provider (ACSP)**

Autism Demonstration Corporate Service Provider (ACSPs) include individual Board Certified Behavior Analyst (BCBA), Board Certified Behavior Analyst–D (BCBA-D) and Licensed Behavior Analyst (LBA), ABA licensed/certified provider, autism centers, autism clinics that contract or employ Assistant Behavior Analysts, and Behavior Technicians (BTs).

ACSP Name: _____

Federal Tax Number: _____

ACSP NPI#: _____

Physical Location (Street Address):

Billing Address for this NPI (If different):

Telephone #: _____

Telephone #: _____

Fax #: _____

Billing Fax #: _____

Date legal entity established: _____

(mm/dd/yyyy)

Are any of the practitioners affiliated with your group also employed by the US Government?

____ Yes ____ No

If yes, please provide the name and NPI of the practitioner

Name: _____

NPI: _____

Will each practitioner sign their own claim form ____ 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.



ACSP Requirements

- ACSP must submit evidence that professional liability insurance in the amounts of 1 million dollars per claim and 3 million dollars in aggregate is maintained in the ACSP's name, unless state requirements specify greater amounts;
- ACSP must comply with all applicable organization and individual licensing or certification requirements that are extant in the State, county, municipality, or other political jurisdiction in which ABA services are provided under Autism Care Demonstration;
- ACSP must certify that all authorized ABA Supervisors, Assistant Behavior Analysts, and Behavior Technicians employed by or contracted with the ACSP meet the education, training, experience, competency, supervision and Autism Care Demonstration requirements specified in TRICARE Operations Manual (TOM) Chapter 18, Section 3;
- ACSP must maintain all applicable business licenses and employment or contractual documentation in accordance with Federal, State, and local requirements, and the authorized ABA Supervisor's business policies regarding, Assistant Behavior Analysts, and BTs;
- ACSP submit documents necessary to support an application for designation as a TRICARE ACSP, must enter into a Participation Agreement and meet all requirements set forth in TRICARE Operations Manual (TOM) Chapter 18, Section 3;
- ACSP must submit claims electronically on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form in accordance with the TOM Chapter 18, Section 3;
- ACSPs must submit a copy of the completed Criminal History Background Check (CHBC) that includes Federal, State, County Criminal and Sex Offender reports for all locations these providers have resided or worked during the previous 10 years for all authorized ABA Supervisors, Assistant Behavior Analysts and BTs.
- ACSP must submit a copy of the completed 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.



ACSP MEMBER LISTING

Please list all BCBA, BCBA-D, LBA, Assistant Behavior Analysts and Behavior Technicians affiliated with your ACSP. Provider payments and remittances are issued at the NPI level; therefore, additional EFT Forms do **NOT** need to be submitted for each member.

PLEASE COMPLETE ALL REQUIRED INFORMATION.

PROVIDER NAME (LAST, FIRST, MID)	SSN NUMBER	NPI NUMBER	PRIMARY SPECIALTY	DATE JOINED GRP
1. _____	_____	_____	_____	_____
LICENSE NUMBER: _____	ORIGINAL DATE: _____	EXPIRATION DATE: _____		
2. _____	_____	_____	_____	_____
LICENSE NUMBER: _____	ORIGINAL DATE: _____	EXPIRATION DATE: _____		
3. _____	_____	_____	_____	_____
LICENSE NUMBER: _____	ORIGINAL DATE: _____	EXPIRATION DATE: _____		
4. _____	_____	_____	_____	_____
LICENSE NUMBER: _____	ORIGINAL DATE: _____	EXPIRATION DATE: _____		
5. _____	_____	_____	_____	_____
LICENSE NUMBER: _____	ORIGINAL DATE: _____	EXPIRATION DATE: _____		
6. _____	_____	_____	_____	_____
LICENSE NUMBER: _____	ORIGINAL DATE: _____	EXPIRATION DATE: _____		
7. _____	_____	_____	_____	_____
LICENSE NUMBER: _____	ORIGINAL DATE: _____	EXPIRATION DATE: _____		
8. _____	_____	_____	_____	_____
LICENSE NUMBER: _____	ORIGINAL DATE: _____	EXPIRATION DATE: _____		

PLEASE PHOTOCOPY THIS FORM IF YOU HAVE MORE THAN EIGHT PROVIDERS.



For each Board Certified Behavior Analyst (BCBA/BCBA-D) and Licensed Behavior Analyst (LBA) working for the ACSP, the following is required:

Provider Name: _____

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 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)?

BACB Certification Number: _____

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

**Attach a copy of BACB certification.*

4. Must have completed training for Basic Life Support (BLS) or 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 a copy of BLS/CPR certification.*

5. Must have a completed Criminal History Background Check (CHBC) that includes Federal, State, County Criminal and Sex Offender reports for all locations the provider has resided or worked during the previous 10 years;

**Attach a copy of the Criminal History Background Check (CHBC)*

6. Have you ever been convicted of a felony? _____ Yes _____ No



For each Assistant Behavior Analysts [Board Certified Assistant Behavior Analyst (BCaBA), Qualified Autism Services Practitioner (QASP) or Licensed Assistant Behavior Analyst (LABA)] working for the ACSP, the following is required:

Provider Name: _____

1. Attach a copy of your Bachelor’s Degree.

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

Name of University: _____

2. Are you state licensed or 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 your state does not offer Licensure, are you certified by the Behavioral Analyst Certification Board (BACB) or by the Qualified Applied Behavior Analysis Credentialing Board (QABA)?

Certification Number: _____

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

**Attach a copy of BACB/QABA certification.*

4. Must have completed training for Basic Life Support (BLS) or 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 a copy of BLS/CPR certification*

5. Must have a completed Criminal History Background Check (CHBC) that includes Federal, State, County Criminal and Sex Offender reports for all locations the provider has resided or worked during the previous 10 years;

**Attach a copy of the Criminal History Background Check (CHBC)*

6. Have you ever been convicted of a felony? _____ Yes _____ No



For each Behavior Technician (BT) working for the ACSP, the following is required:

Provider Name: _____

1. All Behavior Technicians must possess one of the following credentials:

- Registered Behavior Technician (RBT) credential from the Behavior Analyst Certification Board (BACB) OR
- Applied Behavior Analysis Technician (ABAT) credential from the Qualified Applied Behavior Analysis (QABA) credentialing board OR
- Board Certified Autism Technician (BCAT)** credential from the Behavioral Intervention Certification Council (BICC)

**Attach a copy of credential*

2. Must have completed training for Basic Life Support (BLS) or 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 a copy of BLS/CPR certification*

3. Must have a completed Criminal History Background Check (CHBC) that includes Federal, State, County Criminal and Sex Offender reports for all locations the provider has resided or worked during the previous 10 years;

**Attach a copy of the Criminal History Background Check (CHBC)*

4. Have you ever been convicted of a felony? _____ Yes _____ No



**TRICARE Non-Network Participation Agreement for
Autism Care Demonstration (ACD)
Corporate Services Provider (ACSP)**

Name of ACSP: _____

Office Address: _____

Telephone: _____

Tax ID Number: _____

NPI Number: _____



ARTICLE 1

RECITALS

1.1 IDENTIFICATION OF PARTIES

This Comprehensive Autism Care Demonstration Corporate Services Provider (ACSP) 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 “ACSP”).

1.2 AUTHORITY FOR ACSPs AS TRICARE-AUTHORIZED PROVIDERS

The authority to designate ACSPs 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 ACSP as an authorized provider of Applied Behavior Analysis (ABA) services;
- (b) Establish the terms and conditions that the undersigned ACSP 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 ACSP terminates services with any beneficiary for any reason, the ACSP must notify the contractor a minimum of 45 calendar days prior to termination.



2.2 GENERAL AGREEMENT

- (a) The undersigned ACSP 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 ACSP 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 ACSP in accordance with the TOM, Chapter 18, Section 3.

3.2 The ACSP 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 ACSP 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 ACSP which would confirm compliance with this agreement and designation as an authorized ACSP under the ACD.
- (b) Conduct audits of ACSP 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,
Classification: Confidential and Proprietary



or a designee shall have full access to records of TRICARE beneficiaries.

4.2 RECORDS REQUESTED BY DHA

Upon request, the ACSP 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 ACSP 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 ACSP written notice not less than 45 calendar days prior to the effective date of such termination.

5.3 TERMINATION OF AGREEMENT BY THE ACSP

The ACSP 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 ACSP will cease being a TRICARE-authorized provider of Demonstration services. Subsequent to termination, an ACSP 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 CFR 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) An ACSP 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 ACSP 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 ACSP 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: _____

ACSP: _____

By: Signed Name and Title

By: Signed Name and Title

Executed on _____, 20____

(TIN)

(NPI)



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 <i>(legal practice name, not rendering provider)</i> :				
Provider Address: <i>(physical address)</i>	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): <input type="checkbox"/> Savings OR <input type="checkbox"/> Checking	
Provider's Account Number with Financial Institution:	Account Number Linkage to Provider Identifier: <i>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.</i>		
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:	<input type="checkbox"/> Voided Check <input type="checkbox"/> Bank Letter <i>Bank letter must be signed & dated within the last year</i>
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
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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		
<p>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.</p>				
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.