



**TRICARE NON-NETWORK  
ANESTHESIOLOGIST ASSISTANT (AA)  
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 Anesthesiologist 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.

**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: \_\_\_\_\_



To certify you as an **Anesthesiologist Assistant (AA)**, 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.

**Education:** *Is a graduate of a **Master's** level anesthesiologist assistant educational program that:*

- is established under auspices of an accredited medical school
- is accredited by the Commission on Accreditation of Allied Health Educational Programs (successor organization to the Committee on Allied Health Education and Accreditation, or its successor organization)
- includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

Date Graduated: \_\_\_\_\_ Degree Earned: \_\_\_\_\_  
(mm/yyyy)

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

**Licensure:** *If practicing in a state that **does** offer licensure as an Anesthesiologist Assistant please provide the following:*

Anesthesiologist Assistant License Number: \_\_\_\_\_

Original License Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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 \_\_\_\_\_