TRICARE
NON-NETWORK
DONOR MILK BANK SUPPLIER 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 use this application if you are a supplier of:

Donor Milk Bank

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.***

Non-Network Equipment Supplier Application

Corporation Name: _____

Tax ID Number: _____ NPI#: _____

Physical Address (Street Address):

_____

_____

_____

Billing Address for this NPI:

_____

_____

_____

** If you practice at multiple locations, please attach a list of additional office locations.

Telephone #: _____

Billing Telephone #: _____

Fax #: _____

Email: _____

Effective date of the Tax ID number or EIN (Date legal entity established): _____

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 Non-Network Bank Milk Donor**,** 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.

Please provide the following:

Copy of Human Milk Banking Association of North America (HMBANA) accreditation

OR

Listed on the HMBANA accredited website

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: _____