TRICARE NON-NETWORK INSTITUTIONAL 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.***

Revised: 1/7/2025

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Facility Name: _____

Federal Tax ID Number: _____

NPI#_____

Office Location (Street Address): Billing Address for this NPI:

_____ _____

_____ _____

_____ _____

Telephone Number: _____

Date legal entity established: _____

Is the facility MEDICARE certified? ____ Yes ____ No

Certification Number: _____

Original Certification Date: _____

Current Certification Dates: _____ TO _____

Is the facility Joint Commission certified? ____ Yes ____ No

Certification Number: _____

Original Certification Date: _____

Current Certification Dates: _____ TO _____

PLEASE ATTACH COPY OF MEDICARE AND/OR JOINT COMMISSION CERTIFICATION.

What is your facility classified as? (check the most appropriate classification)

____ Ambulatory Surgery Center
____ Children's Hospital
____ Chronic Disease Institute
____ College Infirmary
____ Extended Care Facility
____ Short Term Acute Care Hospital
____ Freestanding Kidney Dialysis Center
____ Swing Bed Unit
____ Psych Unit
____ Psychiatric Hospital
____ Long Term General Hospital
____ Rehab Unit
____Sole Community Hospital
____ Other: _____

If your facility is a new psychiatric hospital, a skilled nursing facility (SNF) or a birthing center, you must complete additional forms. Please contact TRICARE Services or visit to obtain these additional forms.

TRICARE PARTICIPATION AGREEMENT FOR INSTITUTIONAL PROVIDERS

In order to receive payment under TRICARE, _____dba _____ as the provider of services agrees:

1. Not to charge a beneficiary for the following:
    a) Services for which the provider is entitled to payment from TRICARE;
    b) Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements;
    c) Services not medically necessary and appropriate for the clinical management of the presenting illness, injury, disorder or maternity;
    d) Services for which a beneficiary would be entitles to payment but for a reduction or denial in payment as a result of quality review; and
    e) Services rendered during a period in which the provider was not in compliance with one or more conditions or authorization:
2. To comply with applicable provisions of 32 CFR 199 and related TRICARE policy;
3. To accept the TRICARE determined allowable payment combined with the cost-share, deductible, and other health insurance amounts payable by, or on behalf or, the beneficiary, as full payment for TRICARE allowed services;
4. To collect from the TRICARE beneficiary those amounts that the beneficiary has a liability to pay for the TRICARE deductible and cost-share/copayment;
5. To permit access by the Director, DHA, or designee, to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state or private agencies or organizations;
6. To provide to the Director, DHA or designee (e.g., Managed Care Support Contractor), prompt written notification of the provider's employment of an individual who, at any time during the twelve months preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly, for decisions regarding Department of Defense payments to the provider;
7. To cooperate fully with a designated utilization and clinical quality management organization which has a contract with the Department of Defense for the geographic area in which the provider renders services;
8. Comply with all applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/copayment may be expected;
9. To maintain clinical and other records related to individuals for whom TRICARE payment was made for services rendered by the provider, or otherwise under arrangement, for a period of 60 months from the date of service;

10. To maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, the methods, modalities or means of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation or treatment;

11. To refer TRICARE beneficiaries only to providers with which the referring provider does not have an economic interest, as defined in 32 CFR 199.2;

12. To limit services furnished under arrangement to those for which receipt of payment by the TRICARE authorized provider discharges the payment liability of the beneficiary; and

13. Meet such other requirements as the Secretary of Defense may find necessary in the interest of health and safety of the individuals who are provided care and services.

TRICARE PERFORMANCE PROVISIONS FOR INSTITUTIONAL PROVIDERS

Provider shall provide Covered Services to Beneficiaries in accordance with the following terms:

• To cooperate with TriWest Healthcare Alliance in the assumption and conduct of review activities.

• To allocate adequate space for the conduct of on-site review.

• To deliver to TriWest Healthcare Alliance a paper or electronic copy of all required information within 30 calendar days of a request for off-site review.

• To provide all beneficiaries, in writing, their rights and responsibilities (e.g., “An Important Message from TRICARE” (TOM Ch.7, Addendum A), “Hospital Issued Notice of Noncoverage” (TOM Ch. 7, Addendum B).

• To inform TriWest Healthcare Alliance within three working days if they issue a notice that the beneficiary no longer requires inpatient care.

• To assure that each case subject to preadmission/preprocedure review has been reviewed and approved by the contractor.

• To agree, when they fail to obtain certification as required, that they will accept full financial liability for any admission subject to preadmission review that was not reviewed and is subsequently found to be medically unnecessary or provided at an inappropriate level (32 CFR 199.15(g)).

• To agree to provide such medical and other records and such review data and other information as may be required or requested under a Quality Management and Improvement program within ten (10) days of receipt of notice at no cost to the requesting TRICARE entity

• TriWest Healthcare Alliance will provide detailed information on the review process and criteria used, including financial liability incurred by failing to obtain preauthorization.

Defense Health Agency (DHA) agrees to:

Pay the above-named provider the full allowable amount less any applicable double coverage, cost-share/copayment, and deductible amounts.

This agreement shall be binding on the provider and DHA upon acceptance by the Deputy Director, DHA, or designee.

This agreement shall be effective until terminated by either party. The effective date shall be the date the agreement is signed by DHA.

This agreement may be terminated by either party by giving the other party written notice of termination. The provider shall also provide written notice to the public. Such notice of termination is to be received by the other party no late than 45 days prior to the date of termination. In the event of transfer of ownership, this agreement is assigned to the new owner, subject to the conditions specified in this agreement and pertinent regulations.

Institutional Facility:

_____
Signature

_____
Printed Name

_____
Printed Title

Executed on _____, 20_____

_____
TIN

_____
NPI

DHA OR Designee:

_____
Signature

_____
Printed Name

_____
Printed Title

Executed on _____, 20_____

Non-Network UB-04 “Signature on File” for TRICARE Claims Form

Please complete the following information and return by fax to 844-730-1373

This form serves the purpose of the signature requirements indicated in the TRICARE Operations Manual (Chapter 8, Section 4, Paragraph 10.0.)

> “The signature of the non-network provider, or an acceptable facsimile, is required on all participating claims. The provider’s signature block Form Locator (FL) has been eliminated from the CMS 1450 UB-04. As a work around, the National Uniform Billing Committee (NUBC) has designated FL 80, Remarks, as the location for the signature, if signature on file requirements do not apply to the claim. If a non-network participating claim does not contain an acceptable signature, return the claim.”

I, _____hereby authorize PGBA, LLC / TriWest Healthcare Alliance
(print/type name here)

in the state of South Carolina to accept my signature shown below as my true signature for all claim submissions for the facility indicated below.

Facility Name: _____

Facility Tax Identification Number: _____

Facility NPI Number: _____

Facility Physical Address: _____

Facility Phone Number: _____

Signature of Authorized Representative: _____

Revised: 1/7/2025