TRICARE NON-NETWORK SKILLED NURSING FACILITY 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.***

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TRICARE NON-NETWORK SKILLED NURSING FACILITY PROVIDER APPLICATION

Facility Name: _____

Federal Tax 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.

SKILLED NURSING FACILITY (SNF) PARTICIPATION AGREEMENT

Agreement Between TRICARE and _____ (Provider)

doing Business as (DBA) _____

TRICARE Provider ID/Number: _____ Medicare Provider No: _____
(To be completed by TRICARE Contractor) (To be completed by SNF)

In order to receive payment under 32 Code of Federal Regulations (CFR) Part 199,
_____DBA
_____ as the Provider of skilled nursing services, agrees to conform to the provisions of 32 CFR 199 and applicable provisions in TRICARE Manuals and applicable Medicare provisions in 42 CFR.

This Agreement, upon submission by the Provider of skilled nursing services of acceptable assurance of compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by TRICARE, shall be binding on the Provider of skilled nursing services and TRICARE.

The Provider of skilled nursing services certifies that:

a. The Provider is licensed by the State having jurisdiction for the Provider's area.

b. The Provider is Medicare (or Medicaid) certified and will continue to maintain this certification. If at any time the provider is decertified by Medicare (or Medicaid), the provider agrees to notify the TRICARE contractor within 72 hours. Loss of Medicare (or Medicaid) certification will nullify this agreement. Note: For pediatric SNFs, Medicaid certification will be acceptable in lieu of Medicare certification.

c. The Provider will not discriminate against the TRICARE beneficiary in their admission practices or in delivery of medically necessary services due to the level of payment.

d. The Provider will use the same certification forms for TRICARE patients as are used and required for Medicare (or Medicaid) patients. The Provider will provide Notices to TRICARE Beneficiaries in the same manner as they provide under Medicare.

e. The Provider will participate on all TRICARE SNF claims and will accept TRICARE payment as the full payment and not balance bill the TRICARE beneficiaries. The Provider will collect the applicable cost-share amounts from the TRICARE beneficiaries.

TRICARE PERFORMANCE PROVISIONS FOR INSTITUTIONAL PROVIDERS

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

• To cooperate with Health Net Federal Services 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.

In the event of a transfer of ownership, this Agreement is automatically assigned to the new owner subject to the conditions specified in this Agreement and 42 CFR 489, to include existing plans of correction and the duration of this Agreement, if the Agreement is time limited.

Accepted for the provider of skilled nursing services by:

Signature

Printed name and title Date

TIN NPI

Or

Accepted for the successor provider of skilled nursing services by:

Signature

Printed name and title Date

TIN NPI

ACCEPTED FOR DHA AND TRICARE CONTRACTOR BY:

Signature

Printed name and title Date

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: _____

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