



16010 North 28th Avenue
Phoenix, Arizona 85053
Main: 1-888-TRIWEST (874-9378)
www.triwest.com

TriWest Healthcare Alliance Corp. would like to take this opportunity to thank you for your desire to care for TRICARE beneficiaries. Providing quality health care helps ensure that active duty service members, military retirees and their family members are well served. Deployed service members especially take great comfort knowing their family members' health care is secure.

TriWest has made accessing information about the TRICARE program on www.triwest.com/provider easy and convenient for you and your business office staff. Once registration is authenticated, you have direct access to the secure provider portal, allowing you to:

- Verify patient eligibility
- Submit referrals/authorizations online
- Determine status of referrals/authorizations
- Submit claims online
- View claims and check claim status
- Download Explanations of Benefits

In addition, www.triwest.com/provider has several resources located to help you find information regarding TRICARE reimbursement rates, referrals and authorizations, claims and reimbursement, TRICARE programs and benefits, Electronic Data Interchange (EDI), the Resource Library, and more!

Here are some other sources that are designed to assist you in providing care to beneficiaries:

- The **Interactive Voice Response (IVR) system** is available 24-7 by calling 1-888-TRIWEST (874-9378). An IVR Tips Guide is available in the Resource Library at www.triwest.com/provider to guide you through the process.
- **TRICARE Field Representative (TFR)** You may call 1-888-TRIWEST (874-9378) to request the assistance of your local TFR if you need assistance with the TRICARE certification process or if you require education regarding TRICARE.
- **TriWest's eSeminars** offer the convenience of learning about TRICARE programs in the comfort of your office, home or any location with Internet access at a time most convenient to you. Go to www.triwest.com/provider to take an eSeminar.
- **Filing Claims: Electronic Data Interchange (EDI)** Wisconsin Physicians Service (WPS) staff is skilled in implementing EDI strategies with a variety of provider specialties, billing services, and software vendors. Choosing one of their electronic data interchange (EDI) options assures you ample assistance throughout the claims filing process. The EDI edit systems are designed to minimize data entry errors before claims are passed to the WPS processing system. EDI claims are generally processed and paid very quickly.

Thank you again for your interest in providing care to TRICARE beneficiaries in the West Region. For additional information on registering for the secure provider portal, submitting your claims online and signing up to receive ERA, refer to www.triwest.com/provider, or call 1-800-782-2680 (EDI Help Desk).

A handwritten signature in black ink that reads "Lisa Stevens". The signature is written in a cursive, flowing style.

Vice President, Provider Services
TriWest Healthcare Alliance

PHYSICIAN PROVIDER FILE APPLICATION

Date of request ____ / ____ / ____

Name _____

Telephone # (____) _____

National Provider Identifier (NPI) # _____

Fax # (____) _____

Federal Tax ID # _____

Medicare # _____

Are you joining an established group practice? Yes No

Solo Practice: Yes No Both

If Yes: Group Name _____

Address _____

You must complete the Special Authorization form if the group will bill on your behalf.

Date you began filing with group #: ____ / ____ / ____

You must complete an Authorized Signer form if a representative will be signing claim forms on your behalf.

If you are filing your taxes under a Federal Tax Identification number because you are incorporated or belong to an incorporated group/professional association, you must also complete a Group Application form.

Office Location (Street address):

Billing Address (if different):

LICENSE # _____

Temporary/Limited

Permanent Issuing State _____

Date license was first issued ____ / ____ / ____

Expiration Date ____ / ____ / ____

Are you transferring from another state where you had an established practice? YES NO

If Yes: State _____

PRIMARY Specialty _____

Are you:

Hospital-salaried/employed physician?

Yes No

Location

Teaching-setting physician?

Yes No

Employed by the U.S. Government?

Yes No

National Health Service Corporation (NHSC) physician?

Yes No

Intern?

Yes No

Resident?

Yes No

Are you employed by the U.S. Government?

Dual compensation/conflict of interest. Title 5, United States Code, section 5536 **reference [bb]** prohibits medical personnel who are active duty Uniformed Service members or civilian employees of the Government from receiving additional Government compensation above their normal pay and allowances for medical care furnished. In addition, Uniformed service members and civilian employees of the Government are generally prohibited by law and agency regulations and policies from participating in apparent or actual conflict of interest situations in which a potential for personal gain exists or in which there is an appearance of impropriety or incompatibility with the performance of their official duties or responsibilities. The Departments of Defense, Health and Human Services, and Transportation have a responsibility, when disbursing appropriated funds in the payment of TRICARE benefits, to ensure that the laws and regulations are not violated. Therefore, active duty Uniformed Service members (including a reserve member while on active duty) and civilian employees of the United States Government shall not be authorized to be TRICARE providers. While individual employees of the Government may be able to demonstrate that the furnishing of care to TRICARE beneficiaries may not be incompatible with their official duties and responsibilities, the processing of millions of TRICARE claims each year does not enable Program administrators to efficiently review the status of the provider on each claim to ensure that no conflict of interest or dual compensation situation exists. The problem is further complicated given the numerous interagency agreements (for example, resource sharing arrangements between the Department of Defense and the Veterans Administration in the provision of health care) and other unique arrangements which exist at individual treatment facilities around the country. While an individual provider may be prevented from being an authorized TRICARE provider even though no conflict of interest or dual compensation situation exists, it is essential for TRICARE to have an easily administered, uniform rule which will ensure compliance with the existing laws and regulations. Therefore, a provider who is an active duty Uniformed Service member or civilian employee of the Government shall not be an authorized TRICARE provider. In addition, a provider shall certify on each TRICARE claim that he/she is not an active duty Uniformed Service member or civilian employee of the Government.

Are you employed or under a contract which provides for payment to the individual professional provider by an institutional provider? If you are, your application can't be considered. Hospital employees aren't eligible for additional provider numbers outside the realm of the hospital.

Signature of Provider _____

Date _____

CONFLICT OF INTEREST STATEMENT

For TRICARE Providers:

Federal Law (5 U.S.C. 5536) prohibits medical personnel who are active duty members or civilian employees of the government to receive compensation above their normal pay and allowances for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. Claims for TRICARE benefits will be denied in any situation where either a uniform member or civilian employee of the uniform services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selective basis.

Please return to:

WPS TRICARE Provider Certification
P.O. Box 8730
Madison, WI 53708-8730

Please notify us of any changes related to your provider file information (name, address, speciality, tax number, group affiliations, etc.).

AUTHORIZED SIGNER

If a provider elects to use a facsimile signature (rubber stamp) or allow a representative to sign his/her name for certification of the services rendered, it is a TRICARE requirement that we have an authorization from the provider.

Hospital/Clinic Name: _____ Hospital/Clinic IRS Tax Number: _____

Address: _____ City, State, Zip: _____

Each of the below named representatives of this organization are hereby authorized to complete and sign all claim forms required by TRICARE and any related documentation that might be required by fiscal administrators of TRICARE on behalf of all physicians, dentists and other allied science professional staff members for authorized services, care and treatment rendered in the hospital or clinic to TRICARE patients.

The undersigned understands that this is continuing authorization and that the data on such claim forms is entered with the same authority, accuracy and effect as though executed by a member of the professional staff on whose behalf the form is completed. We understand that this authorization shall remain in effect until cancelled or modified in writing by the undersigned or our successors in office.

The agents' signatures and typed names and official titles with the organization as authorized above are as follows:

Signature Printed Name Official Title

Signature Printed Name Official Title

Signature of President (or other authorized officer of the governing body of the hospital, clinic or association) Date

COMPUTER GENERATED FACSIMILE OR RUBBER STAMP AUTHORIZATION

Name: _____ NPI #: _____ IRS Tax#: _____

Address: _____ City, State, Zip: _____

_____ being first duly sworn, deposes and says: I hereby authorize Wisconsin Physicians Service Insurance Corporation to accept my facsimile or stamp signature, shown below, as my true signature for all purposes under the TRICARE program in the same manner as if it were my actual signature.

Actual Signature (Facsimile or Stamp Signature)

Subscribed and sworn to before me this _____ (date) day of _____ (month), 20_____.

NOTARY PUBLIC IN AND FOR _____

county, state of _____, my commission expires _____ (SEAL)