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 o 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).

Lisa D Stevens

Vice President, Provider Services
TriWest Healthcare Alliance

Dear Provider:

TRICARE Management Activity (TMA) is implementing a change to the policy for reimbursement of ambulance services, effective August 1, 2003. The change will allow for reimbursement based on the following factors:

- Local ordinances/regulations mandating Advanced Life Support (ALS) as a minimum standard of transportations
- ALS versus Basic Life Support (BLS) vehicle availability.
- Reimbursement based on the type of service provided in conjunction with the type of vehicle used when no local ordinance/regulation exists.

To identify the localities in which it is mandated that ALS is the minimum standard of patient transportation, we are requesting you submit information regarding the ordinance/regulation for your locality, if any.

Please provide a copy of the local ordinance/regulation mandating your use of ALS as the minimum standard of patient transportation for the localities your company serves. Future changes to the ordinance/regulation should also be forwarded as soon as you are notified of a change. If this information is not received, you will continue to be reimbursed based on the type of vehicle used and/or the level of service needed. This information should be sent to the following address:

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

In addition, TMA is also allowing payment consideration for ambulance services and/or supplies provided by ambulance personnel at an accident scene. The services and supplies may be payable when a patient's condition warrants transfer to an inpatient acute setting and the medical services and/or supplies are provided solely to stabilize the patient's condition while awaiting a more urgent means of transportation, e.g., air ambulance. In an effort to streamline claims processing when these situations occur, please ensure the reason for non-transport of the patient is provided on each claim.

AMBULANCE
PROVIDER FILE APPLICATION

Date of Request _____ /_____ /_____

Name____

Telephone # (_____)_________________________

Federal Tax ID # _________________________________

Fax # (_____)_________________________________

National Provider Identifier (NPI) # __________________

Medicare # _________________________________

Is this Ambulance Service: (check appropriate box)

- ❑ Privately Owned
- ❑ Owned & Operated by a municipality
- ❑ Part of a funeral business
- ❑ A volunteer organization that does not charge for services but asks for a donation to help offset the cost of the service
- ❑ A volunteer organization that regularly charges for its services
- ❑ Provided without charge to residents of a particular geographical area
- ❑ Used for non-emergency transport services

GARAGE/LOCATION (Street Address):

____

____

____

Billing Address if different:

____

____

____

LICENSE # ______________________________________

❑ Issuing State_____________________________

Date license was first issued _____ /_____ /_____

Expiration Date _____ /_____ /_____

I certify that with regard to any and all ambulance services billed under the name _____________________________ to Wisconsin Physicians Service Insurance Corporation, as TRICARE Fiscal Intermediary, the vehicle(s) used and/or its (their) operator(s) meet all the following requirements for eligibility to receive payment for services provided to eligible beneficiaries of the TRICARE programs.

I further agree to immediately notify Wisconsin Physicians Service Insurance Corporation of any change in personnel or operations which will affect this certificate.

Signature ____ Date ________________________________

Title ____ Phone Number _______________________

A statement signed by state or local authorities must accompany this application as documentation of the equipment requirement. (Documentary evidence may include a copy of a license, permit, certificate, etc., issued by the authorities.)

VEHICLE(S)

1. Identification:

Year _______ Model ___________ I.D. No. _________

Year _______ Model ___________ I.D. No. _________

Year _______ Model ___________ I.D. No. _________

If additional vehicles, list on separate sheet.

EQUIPMENT

2. Basic Equipment

a. Stretcher
b. Clean linens
c. First aid supplies
d. Oxygen equipment
e. Other safety and lifesaving equipment required by state or local authorities.

3. Advanced Life Support (ALS) Equipment:

a. SIV (Intravenous therapy)
b. Anti-shock trousers
c. Establish & maintain patient's airway
d. Defibrillation of the heart
e. Relieve pneuothorax conditions
f. Cardiac (EKG) monitoring
g. Appropriate radio/telephone equipment
h. Other (specify)

____

____

NOTE: Attendants using ALS equipment must hold intermediate or above licensure.

THE ATTENDANTS

There must be at least two (2) ambulance attendants. Those attendants charged with the care or handling of the patient must be licensed in accordance with the appropriate state statutes.

Name ____

Training ____
(Specify) ❑ Basic ❑ Intermediate ❑ Paramedic

License Number __________________________________

Name ____

Training ____
(Specify) ❑ Basic ❑ Intermediate ❑ Paramedic

License Number __________________________________

Name ____

Training _ ______________________________________
(Specify) ❑ Basic ❑ Intermediate ❑ Paramedic

License Number __________________________________

List additional attendants on separate sheet

Please return to:

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

SPECIAL AUTHORIZATION

I certify that I am an associate with the ______________________________
(Name of Clinic Association)

whose address is ______________________________

____

I also certify that I am not an intern or resident, and that I am licensed as indicated in this state (or, if licensing is not required, that I am eligible for membership in the national or state organization setting the standards for my allied science specialty).

I hereby authorize any of the duly authorized representatives of the above named organization as my agents to submit on my behalf claims for services provided TRICARE beneficiaries, and to receive on my behalf any payments which may be made pursuant to submission of such claims. It is understood and agreed that claims will be submitted only for services which are medically indicated for the proper care of the patient, and the services (where provided by other than a physician or dentist) were ordered by the attending physician or dentist and that the services were actually furnished.

I understand that I may withdraw this authorization at any time by giving written notice of such fact to the above named organization.

I also agree to hold the United States and its Fiscal Administrators under TRICARE harmless for any losses that might occur to me as the result of any action on the part of representatives of the above named organization after payment has been made by the United States or its Fiscal Administrators to said organizations for services which I have rendered, pursuant to a billing and claim submitted in my behalf in accordance with the terms of this agreement.

I also understand the making or conspiring to make a false, fictitious or fraudulent claim against the United States or one of its Fiscal Administrators renders such person liable to prosecution under applicable federal law.

Name, Title, and Signature	**Specialty and Social Security Number**	**State License Number if Required or Organization**
____________	____________	
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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)

21148-097-0902