



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 style with a large, looped "L" and "S".

Vice President, Provider Services
TriWest Healthcare Alliance

**PROGRAM INFORMATION
NEW PSYCHIATRIC HOSPITAL
PENDING JC ACCREDITATION**

Facility No: _____

Date: _____

The information collected will assist the Government in determining whether your facility can be considered an approved source of care, for payment purposes, under the TRICARE Program. The information will also aid the Government in assisting TRICARE beneficiaries and representatives of the Uniformed Services in locating appropriate sources of care when there is a requirement for specialized care and treatment programs.

1. Facility Name 	2. Facility Address 				
3. Is your facility address different from your mailing address or the address where payments are sent? <input type="checkbox"/> Yes (indicate address) <input type="checkbox"/> No					
4. Telephone Number ()	5. Name and Title of Chief Administrator 				
6. Organizational Structure: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Single Owner <input type="checkbox"/> Public Agency <input type="checkbox"/> Professional Corporation <input type="checkbox"/> Group Practice or Association	7. Type of Ownership: <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Private Not-For-Profit <input type="checkbox"/> Private For Profit				
8. For admission or acceptance into your program are there restrictions based on an individual's race, color, or national origin? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. After admission are patients treated equally without regard to race, color, or national origin? <input type="checkbox"/> Yes <input type="checkbox"/> No				
10. Total number of surgical units in your facility? 	11. Indicate how your facility restricts admissions by: Sex _____ Age _____ Geographic Area _____				
12. Is the course of treatment for all patients prescribed and supervised by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No (explain your arrangements for physicians services)					
13. Indicate the system(s) used to evaluate the facility's program: <table style="width:100%; border:none;"> <tr> <td style="width:25%;">Contractual Evaluation And/Or Programmatic Consultation <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="width:25%;">Professional Services Review Organization <input type="checkbox"/> Participate <input type="checkbox"/> Do Not Participate</td> <td style="width:25%;">Utilization Review <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> None <input type="checkbox"/> N.A.</td> <td style="width:25%;">Patient Representative <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> Patient, Family or Staff Advisory Committee <input type="checkbox"/> Active <input type="checkbox"/> Not Active		Contractual Evaluation And/Or Programmatic Consultation <input type="checkbox"/> Yes <input type="checkbox"/> No	Professional Services Review Organization <input type="checkbox"/> Participate <input type="checkbox"/> Do Not Participate	Utilization Review <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> None <input type="checkbox"/> N.A.	Patient Representative <input type="checkbox"/> Yes <input type="checkbox"/> No
Contractual Evaluation And/Or Programmatic Consultation <input type="checkbox"/> Yes <input type="checkbox"/> No	Professional Services Review Organization <input type="checkbox"/> Participate <input type="checkbox"/> Do Not Participate	Utilization Review <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> None <input type="checkbox"/> N.A.	Patient Representative <input type="checkbox"/> Yes <input type="checkbox"/> No		
14. Patient Information: Number of Licensed Beds _____	Number of Patients During The Last Twelve Months _____	Current Patient Census _____			
15. Provide the following additional information: a. Copy of state or local operating license. b. Copy of your Medicare Certification Letter. c. Copy of all correspondence with JCAHO. d. Most recent state or local fire and health inspection reports. e. Schedule of rates and charges for all services. (Would charges for TRICARE beneficiaries differ from the charges incurred by others? If so, explain.) f. Current brochure, pamphlet, etc., describing your overall program.					
18. Name of Facility Representative 	19. Signature 	20. Date 			

INSTITUTIONAL PROVIDER FILE APPLICATION

Date of Request ____/____/____

Facility name _____

Federal Tax ID # _____ National Provider Identifier (NPI) # _____

Corporate ownership (Appears on 1099) _____

Physical location (street address):

Billing or reimbursement address (if different):

Corporate address* _____

Tax exempt Yes No

Tax exempt # _____

* 1099 will be generated to corporate office

Please have your billing staff complete the Official Designation of your Clinic or Association form, if they will be signing claims for your organization. These forms may be duplicated as needed.

To complete your certification we will need:

- Copy of your state licensure(s)
- Copy of your JCAHO—include your expiration date (mo/day/year)
- Copy of your Medicare certification and any exempt status (Psych, Rehab, Skilled Nursing). If you are exempt from the Medicare Perspective Payment System you will also be exempt for TRICARE
- Exempt facilities/units complete room rate form

If your facility/unit is either a Partial Hospitalization Program (PHPs), Residential Treatment Center (RTCs) or Substance use Disorder Rehabilitation Facilities (SUDRFs) not licensed as a hospital, please direct your request for certification to:

MAXIMUS (NQMC – National Quality Monitoring Contractor) at (602) 308-7160.

- A. Does your facility have an intern or residency program? Yes No
- B. Are you a teaching facility? Yes No
- C. Does your hospital employ any personnel, part time or full time, who are active duty members of the armed services or civilian employees of the federal government? Yes No

**TRICARE Room Rate and Facilities Report
Perspective Payment System Exempt Hospitals and Units Only**

All room rates reported below Check one Month Day Year
 became effective
 will become effective

This institution has Check one Range of private room rates
 PRIVATE ROOMS ONLY From To
 PRIVATE ROOMS in addition to others \$ \$
 NO PRIVATE ROOMS

This institution charges Check one Range of flat rates
a FLAT RATE by the day From To
 week \$ \$
 month \$ \$

This institution has the following	Type of special care room	Rate \$
SPECIAL CARE rooms, units and/or wards and rates		
_____	_____	_____
_____	_____	_____
_____	_____	_____

This institution has SEMIPRIVATE (GENERAL CARE) ROOMS at the following rates	Number of beds in each semiprivate room	Number of rooms	Rate for each bed (\$)
	2	_____	_____
	3	_____	_____
	4	_____	_____

The rates shown above are the same as those charged to the general public.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Signature _____ Title _____ 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, 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, specialty, 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)