



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.

Vice President, Provider Services
TriWest Healthcare Alliance

ALLIED HEALTH PROVIDER FILE APPLICATION

Registered Nurse (RN), Licensed Practical Nurse (LPN), Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST, CCC), Optometrist (OD), Anesthesia Assistant (AA), Certified Registered Nurse Anesthetist (CRNA), Advanced Nurse Practitioner (ANP)

Date of Request ____ / ____ / ____

Name _____ Telephone # (____) _____

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

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.

Are you joining an established group practice? Yes No

If Yes: Group name _____ Provider # _____

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

Date you began filing with the group provider no. ____ / ____ / ____

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

Office Location (Street address):

Billing Address if different:

Do you maintain a solo practice? Yes No

LICENSE # _____

Temporary/Limited

Enclose copy of licensure/certification.

Permanent Issuing state _____

Date license was first issued ____ / ____ / ____

Expiration Date ____ / ____ / ____

Medicare # _____

Primary specialty _____

If licensing is not required, but you are a member (or eligible) in the state or national association setting standards for your profession, please indicate.

State or national organization _____

_____ State or _____ National

_____ Member or _____ Eligible

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)