



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".

Vice President, Provider Services
TriWest Healthcare Alliance

TRICARE West Region
"Whatever It Takes"

HOME HEALTH AGENCY PROVIDER FILE APPLICATION

Date of Request ____ / ____ / ____

GROUP NAME _____ Fax # (____) _____

Federal Tax ID # _____ Telephone # (____) _____

National Provider Identifier (NPI) # _____

Office Location (Street Location):

Billing Address (if different):

Corporate Name _____

Your staff may sign TRICARE claim forms on your behalf when the necessary **Authorized Signer** form has been completed.

Special Authorization form should be completed by all members of your professional staff if payment is being made in the name of the organization (i.e., clinic, group, or partnership).

Medicare certified Yes No Medicare # _____

Complete W-9 form.

Will you submit claims using revenue code 0023? Yes No

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.).

RE: Corporate Services Provider Class

Dear TRICARE Provider,

TRICARE supplements the availability of health care in military hospitals and clinics. TRICARE beneficiaries, like other health care consumers, now have access to a wide array of health care delivery systems that were not initially recognized or reimbursed under the program. As a result, TRICARE has established a provider class consisting of freestanding corporations and foundations that render principally professional, ambulatory or in-home care and technical diagnostic procedures. This provider class will be called Corporate Services Provider.

Types of corporations:

- Home Health Agencies
- Radiation therapy programs
- Cardiac catheterization clinics
- Free-standing sleep disorder diagnostic centers
- Independent physiological laboratories
- Free-standing kidney dialysis centers
- Free-standing magnetic resonance imaging centers
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Free-standing Bone Marrow Transplant Centers
- Home Infusion
- Urgent Care Clinics

The intent of this provider class expansion is not to create additional benefits that ordinarily would not be covered under TRICARE if provided by a more traditional health care delivery system (i.e., care traditionally offered in a hospital setting), but rather to allow those services which would otherwise be allowed except for an individual Provider's affiliation with a freestanding corporate entity.

For further information on the Corporate Services Provider, visit the TMA website:

www.TRICARE.osd.mil/TRICAREManuals/

Click on TRICARE Policy Manual then browse entire manual

Policy Chapter 11, section 12.1

Policy Chapter 11, addendum D

Attached is the Corporate Services Provider Status application and a Participation Agreement. Please fill out all attachments and return by fax (608) 223-0613 within three business days.

Your assistance in this process is greatly appreciated.

Sincerely,
WPS TRICARE Provider Certification Unit

20975-097-0908

APPLICATION FORM FOR CORPORATE SERVICES PROVIDERS

Application For TRICARE-Provider Status

CORPORATE SERVICES PROVIDER

The public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR APPLICATION TO THE ABOVE ADDRESS.

DIRECTIONS

- To apply for certification as a TRICARE-authorized provider, read and complete all sections of this application and return it with all the attachments to the following address:

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

Provider Name: _____

NOTE: All applications must be signed by the chief executive office and dated:

The above-named provider has applied to become a TRICARE-authorized provider. The signee certifies that the information in this application and attachments is true and accurately represents and depicts the above named provider.

Chief Executive Officer: _____

Date: _____

Participation Agreement

In order to receive payment under TRICARE, _____

dba _____, as the provider of services agrees:

1. Not to charge a beneficiary for the following:
 - a. Services for which the provider is entitled to payment from TRICARE;
 - b. Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements;
 - c. Services not medically necessary and appropriate for the clinical management of the presenting illness, injury, disorder or maternity;
 - d. Services for which a beneficiary would be entitled to payment but for a reduction or denial in payment as a result of quality review; and
 - e. Services rendered during a period in which the provider was not in compliance with one or more conditions of authorization:
2. To comply with applicable provisions of 32 CFR 199 and related TRICARE policy;
3. To accept the TRICARE determined allowable payment combined with the cost-share, deductible, and other health insurance amounts payable by, or on behalf of, the beneficiary, as full payment for TRICARE allowed services;
4. To collect from the TRICARE beneficiary those amounts that the beneficiary has a liability to pay for the TRICARE deductible and cost-share/co-payment;
5. To permit access by the Executive Director, TMA, or designee, to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state or private agencies or organizations;
6. To provide to the Executive Director, TMA, or designee, prompt written notification of the provider's employment of an individual who, at any time during the twelve months preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly, for decisions regarding Department of Defense payments to the provider;
7. To cooperate fully with a designated utilization and clinical quality management organization, which has a contract with the Department of Defense for the geographic area, in which the provider renders services;
8. Comply with all applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/co-payment may be expected;
9. To maintain clinical and other records related to individuals for whom TRICARE payment was made for services rendered by the provider, or otherwise under arrangement, for a period of 60 months from the date of service.

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)