TRICARE®
PHYSICIAN/DENTIST/PT/OT
PROVIDER APPLICATION

Please submit the completed application package to:

Fax:
803-462-3986

or

Mail to: TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039

Authorization as a TRICARE provider does not include a network or contractual agreement with Humana Military Healthcare Services. To become a TRICARE-contracted Network Provider for the South Region, please visit www.humana-military.com to inquire about joining the network.

Humana. Military

TRICARE South Region
Provider Data Management
P.O. Box 7039
Camden, SC 29020-7039
Fax 803-462-3986

Toll-Free: 1-800-403-3950
www.myTRICARE.com by PGBA

Physician/Dentist
Provider Application Package

TRICARE
PROVIDER FILE APPLICATION

NAME: _____

SOCIAL SECURITY NUMBER: _____ NPI#: _____

Do you maintain a solo practice? ☐ YES ☐ NO

IF YOU ARE SOLO INCORPORATED, PLEASE GIVE EIN NUMBER: _____

OFFICE LOCATION (Street Address): BILLING ADDRESS (If different):

_____ _____

_____ _____

_____ _____

Office Tele. No: (_____) _____-_____ ext. _____ Billing Tele. No: (_____) _____-_____ ext. _____

Are you a member of an established group practice or institution? ☐YES ☐ NO

If YES, Practice Name: _____

Tax ID Number: _____ NPI#: _____

Date you began filing with group number: _____/___/_____

It is agreed that _____ will bill for and
(Name of Clinic, Group or Professional Association)

receive any charges or fees for my services.

_____ _____
Signature: Authorized Individual for Clinic Signature of Practitioner

_____ _____
Date Date

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PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

STATE OF _____ COUNTY OF _____

Know all persons by these presents:

That I, _____

☐ have made, constituted and appointed and by these presents do make, constitute and appoint _____ (Please attach a list of any other authorized representatives) my true and lawful attorney-in-fact for me and in my name, place and stead to sign my name on claims, for payment for services provided by me submitted to TRICARE Management Activity (TMA). My signature by my said attorney-in-fact includes my agreement to abide by the TRICARE payment system concept and the remainder of the certification appearing on all TRICARE claim forms. I hereby ratify and confirm all that my said attorney-in-fact shall lawfully do or cause to be done by virtue of the power granted herein.

And/or

☐ being first duly sworn, deposes and says: I hereby authorize the contractor for TRICARE to accept my facsimile or stamp signature shown below:

_____
(Facsimile, stamp or computer-generated signature as it will appear on the claim form, type or print for electronic claims)

as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the TRICARE payment system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

_____
(PROVIDER SIGNATURE)

In witness whereof I have here unto set my hand this _____ day of _____, 20_____.

_____
SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 20_____

_____
NOTARY PUBLIC IN AND FOR

COUNTY OF _____ STATE OF _____

(SEAL) MY COMMISSION EXPIRES _____/_____/_____

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SECTION F

ATTACH A PHOTOCOPY OF YOUR LICENSE OR CERTIFICATION

License No.: _____ Issuing State: _____

NPI: _____ ☐ Permanent ☐ Temporary/Limited

Original License Date: _____/___/_____

Current License Effective Dates: From _____/___/_____ To _____/____/____

Primary Specialty: _____

Are you an INTERN? ☐ YES ☐ NO Are you a RESIDENT? ☐ YES ☐ NO

If RESIDENT, name of facility where you are completing your residency:

_____

BEGIN DATE: _____/___/_____ COMPLETION DATE: _____/___/_____

What date did you begin your first Practice for which payment was made outside the scope of an intern or training program (i.e. date you began practicing after you completed your residency)?

___/___/_____

I, the undersigned provider, in submitting this application for certification as an authorized provider under the TRICARE program, do affirm and attest that the information which I have provided in response to and support of this application is true and correct. I understand that any misrepresentation of my credentials which bear upon my qualification for authorized TRICARE provider status may be subject to the Administrative Remedies for Fraud, Abuse and Conflict of Interest as defined in Chapter 9 of the TRICARE Regulation, 32 CFR 199.9.

_____ _____

Signature of Applicant Signature Date