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

PROGRAM INFORMATION
SPECIALIZED TREATMENT FACILITIES
AMBULATORY SURGICAL CENTERS

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?
☐ Yes (indicate address)

☐ No

4. Telephone Number
(   )

5. Name and Title of Chief Administrator

6. Organizational Structure:
☐ Corporation ☐ Partnership ☐ Single Owner
☐ Public Agency ☐ Professional Corporation
☐ Group Practice or Association

7. Type of Ownership:
☐ City ☐ County ☐ State
☐ Private Not-For-Profit ☐ Private For Profit

8. For admission or acceptance into your program are there restrictions based on an individual's race, color, or national origin? ☐ Yes ☐ No

9. After admission are patients treated equally without regard to race, color, or national origin?
☐ Yes ☐ 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?
☐ Yes ☐ No (explain your arrangements for physicians services)

13. Identify your patient population. ☐ Restorative Phase (outpatient) ☐ Other (specify)

14. Indicate the system(s) used to evaluate the facility's program:

Contractual Evaluation And/Or Programmatic Consultation
☐ Yes ☐ No

Professional Services Review Organization
☐ Participate ☐ Do Not Participate

Utilization Review
☐ Active ☐ Inactive
☐ None ☐ N.A.

Patient Representative
☐ Yes ☐ No

Patient, Family or Staff Advisory Committee
☐ Active ☐ Not Actively

15. Number of TRICARE patients your facility treated during the last 12 months.

16. Number of TRICARE patients your facility referred to other health care providers during the last 12 months.

17. Provide the following additional information:

a. If accredited by Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare/Medicaid, submit the results of the latest onsite visit by any of those three agencies, including the approval letter, list of recommendations, and your written plan of correction on each deficiency/recommendation. Accreditation by one of the above is a prerequisite for TRICARE approval.
b. Copy of state or local operating license. If a license is not required for your facility, furnish a statement from an appropriate state or local official establishing that your facility provides services in accordance with provisions of local or state law.
c. Most recent state or local fire and health inspection reports.
d. Schedule of rates and charges for all services. (Would charges for TRICARE beneficiaries differ from the charges incurred by others? If so, explain.)
e. A current brochure, pamphlet, etc., describing your overall program.
f. Names and disciplines of all professional staff (indicate full or part-time).

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 ☐ became effective ☐ will become effective	Month	Day	Year

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

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

This institution has the following SPECIAL CARE rooms, units and/or wards and rates

Type of special care room	Rate $

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.).

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

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)