

# TRICARE NON-NETWORK EQUIPMENT SUPPLIER APPLICATION

We expect providers to submit claims electronically. If it is necessary to submit a paper claim, the only acceptable forms are the approved **red and white** NUCC 1500 (02-12) form and the NUBC UB-04 (CMS -1450) forms. These forms must include the instructions on the back page.

#### Please use this application if you are a supplier of:

Durable Medical Equipment (DME)
Durable Equipment (DE)
Assistive Technology (AT)

Please submit the completed application package to:

Fax: 844-730-1373

or

Mail to:

TRICARE West
Provider Data Management
PO Box 202106
Florence, SC 29502-2106

Health Net Federal Services offers payments and remittances by National Provider Identifier (NPI) number. **The NPI billed on the claim will determine where payment and remittance will be sent.** It is critical the information provided matches how your office will file claims. Inconsistent data will negatively impact claims payment.

If your business requires multiple mailing/payment addresses, please provide an NPI for each. If you have more than one NPI, you must complete a separate application for each NPI number.

Revised: 12/6/2018



## Non-Network Equipment Supplier Application

Corporation Name:	
Tax ID Number:	NPI#:
Physical Address (Street Address):	Billing Address for this NPI:
** If you practice at multiple locations, please a	attach a list of additional office locations.
Telephone #:	Billing Telephone #:
Fax #:	Email:
Effective date of the Tax ID number or EIN (Da	ate legal entity established):
Do you sign your own claim forms? Yes	No
each practitioner. Without signature authorizat from the rendering provider and claims withou payment.	ned. Please complete these forms and have them notarized for tion forms on file, each claim will require a physical signature t signature will be returned without processing the claim for
To certify you as a Non-Network <b>Equipment </b> \$ you meet TRICARE requirements. PGBA, LLC determine provider eligibility. To confirm you n	Supplier, please provide the following information to confirm common must have complete provider documentation on file to neet requirements, the information provided must be legible, or provide complete and accurate information will negatively
Please provide the following:	
Medicare Certification Number:	
Original Certification Date:	Current Expiration Date:
*If not Medicare certified, please provide a business name and address.	a photocopy of a printed receipt or invoice which includes the
U.S.C. 287 and 1001 provide for criminal pena	e TRICARE requirements. I understand that federal laws 18 alties for submitting knowingly or making any false, fictitious or thin the jurisdiction of any department or agency of the United
Practitioner Signature:	Date:



## PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

State of	_			
County of	_			
	being first duly sworn, dep	oses and says: I hereby		
authorize PGBA, LLC / Health Net Federa	al Services in the state of South (	Carolina to accept my		
facsimile or stamp signature shown below	v.			
(Facsimile, stamp or computer gene	erated signature as it will appear	on the claim form.)		
as my true signature for all purposes unde	er TRICARE in the same manne	r as if it were my actual		
signature, including my agreeing to abide	by the TRICARE payment syste	em concept and the		
remainder of the certification normally sig	ned by the source of care as it a	ppears on all TRICARE		
claim forms.				
-	Signature	Signature		
Subscribed and sworn to before me this _	day of	20		
Notary F	Public in and for			
·	County, State of			
(SEAL)				
My Commission expires		_		



## PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

State of					
County of		-			
Know all persons by these prese	nts:				
That I,			have made, c	onstituted and	l appointed and
by these presents do make cons	titute and	appoint			my true
and lawful attorney-in-fact for me	and in my	y name pla	ce and stead	to sign my nar	me on claims, for
payment for services provided by	/ me subm	itted to TR	ICARE. My si	gnature by my	said attorney-
in-fact includes my agreement to	abide by	the TRICAI	RE payment s	system concep	t and the
remainder of the certification app	earing on	all TRICAF	RE claim form	s. I hereby rati	ify and confirm
all that my said attorney-in-fact s	hall lawful	ly do or cau	ise to be don	e by virtue of t	he power
granted herein.					
In witness whereof I have hereur	nto set my	hand this _	day	of	20
			S	ignature	
Subscribed and sworn to before	me this		day of		_ 20
	Notary Pu	ıblic in and	for		
			County, State	of	
(SEAL)					
My Commission expires					