

TRICARE OVERSEAS PRE-ENROLLMENT INSTRUCTIONS - FOREN



HOW LONG DOES PRE-ENROLLMENT TAKE?

- You may start submitting claims immediately

WHERE SHOULD I SEND THE FORMS?

- Fax the forms directly to Tricare

WHO CAN SIGN THE FORMS

- Forms should be signed by the provider or someone the provider has authorized to sign

WHAT FORM SHOULD I DO?

- TriCare Pre-Enrollment Form

HOW DO I CHECK STATUS?

- There is no need to check status; you may start transmitting your claims immediately. Office Ally's submitter number is 98366.

WHAT PROVIDER NUMBER DO I USE?

- List your tax ID and NPI number where indicated



WPS/TRICARE
 1717 W Broadway
 P.O. Box 8128
 Madison, WI 53708

TRICARE OVERSEAS

Dear TRICARE Provider:

Thank you for choosing the electronic method for submission of your healthcare claims. Wisconsin Physicians Service requires that all new electronic providers /groups sign, and have on file, a "Provider Agreement to Submit Electronic Media TRICARE Claims" prior to claim submission. We request that you complete and return the agreement form, including this cover letter, to our office. *This TRICARE EDI Agreement is for TRICARE Overseas.*

An organization that has several providers can execute a single Provider Agreement form on behalf of the group. Only one authorizing individual is needed to sign the agreement for the Clinic/Group. However, we do need a complete list of all locations and providers for which you will be billing. Please include this as an attachment.

Physician Clinic Name:		
Clinic or Provider Tax ID (EIN) or NPI: (if applicable)	TaxID:	NPI:
Claim Type: (select one or both):	<input checked="" type="checkbox"/> Professional <input type="checkbox"/> Institutional	
Contact Name:		
Contact Phone information	Phone number:	Fax number:
Contact E-mail Address:		
Provider/Clinic/Institution Physical Location Address:	(1) (2) (3) <i>If you have multiple locations, please attach a list including the associated billing/payment address.</i>	

Please indicate your EDI submission option:

- Direct** (using vendor supplied EDI software program and transmitting from your site)
Name of Vendor if Billing direct (if applicable):
- PC-Ace software – Free claims submission software supplied by WPS**
- Clearinghouse or Billing service**
Name of Billing Service/Clearinghouse (if applicable): Office Ally Sub. ID 98366
- Tricare-overseas.com Online Claim submission**

Please indicate your method of transmission if sending Direct or using PC-Ace software. If you are a clearinghouse or Billing Service please indicate your mode of transmission:

_____ **WPS-batch Internet claim submission** X **WPS Bulletin Board System**

*Please note: A faxed copy or original will be accepted. Please mail or fax your completed agreement to:

Electronic Data Services
 Wisconsin Physicians Service
 P.O. Box 8128
 Madison, WI 53708-8128
Fax (608) 223-3824

Sincerely,
 WPS Electronic Data Services

===== **For Office Use Only** =====

Tax ID. _____, _____, _____, _____

Sub # _____ CH _____ Direct _____ Tricare-overseas.com _____

_____ Access Database _____ ALS _____ App Dt _____

Orig Sub # _____ New Sub # _____ Memo _____ ERAU _____ Initials _____

**PROVIDER AGREEMENT FOR TRANSMISSION OF
ELECTRONIC MEDIA TRICARE TRANSACTIONS TO
WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION**

This Provider Agreement for Transmission of Electronic Media TRICARE Transactions to Wisconsin Physicians Service Insurance Corporation (this "Agreement") is entered into between the undersigned health care provider ("Provider") and Wisconsin Physicians Service Insurance Corporation ("WPS") and is effective as of the last date it is signed below.

Provider acknowledges that WPS has entered into a subcontract with a TRICARE Managed Care Support Contractor (the "Contractor") and that the terms and conditions set forth below are necessary for the electronic transmission and submission by Provider and WPS of health care transactions with respect to the U.S. Department of Defense TRICARE program.

1. In submitting electronic transactions, Provider will follow the specifications required by the most current version named under the HIPAA Transactions and Code Sets rules.
2. For claim transactions, Provider agrees that each and every claim submitted via electronic media, for all legal and other purposes, will be considered to be signed by Provider or Provider's authorized representative.
3. For claim transactions, Provider agrees to maintain a patient signature file. Provider understands WPS may validate through file audits those claims submitted via electronic media which are included in any quality control or sampling method requested by WPS. Provider understands that if no signed authorization is on file, an authorization must be obtained by the Provider from the patient prior to electronic submission to WPS.
4. Provider acknowledges that WPS shall have no obligation with respect to the content of the information in claims to verify, check or otherwise inspect the information supplied by Provider. Provider further acknowledges that the Contractor is solely responsible for determining the completeness, accuracy and validity of the information and claims and that source documents for claims data are the responsibility of Provider.
5. WPS may apply edits as defined in the X12 ASC Implementation Guide or the WPS-TRICARE Companion Guide against any transaction. Provider understands that WPS will accept all valid transactions which meet such edit requirements and return errant transactions for correction.
6. This Agreement will terminate automatically at the termination of WPS' subcontract with the Contractor.
7. All notices under this Agreement and correspondence with WPS on technical systems matters shall be sent by Provider to:

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
Madison, Wisconsin 53708-8128
8. This Agreement may not be modified or changed orally. All modifications must be in writing signed by both parties and must be consistent with WPS' obligations under its subcontract with the Contractor and with applicable federal law.
9. This Agreement shall be binding upon the successors or assigns of the parties. However, it shall not be assigned by either party without the written consent of the other party; such approval shall not be withheld unreasonably.
10. It is agreed that the relationship of the parties is that of independent contractors. Neither party is acting as the as agent, partner or employee of the other party.

11. By executing this Agreement below, the parties agree to all of the terms and conditions of the Agreement. Provider further agrees to begin to transmit claims electronically to WPS only after Provider has received a written notice from WPS stating permission to do so has been granted.

Name of Provider

WISCONSIN PHYSICIANS SERVICE
INSURANCE CORPORATION

Tax ID Number of Provider

NPI Number of Provider

Provider Payment Address

By _____
*Signature and Title of Provider
or Authorized Officer*

By _____
WPS Authorized Signature

Date

Date