WELCOME TO OFFICE ALLY!

WPS TRIWEST TRICARE

THE TRICARE SOUTH REGION IS ADMINISTERED BY WPS IN WISCONSIN AND INCLUDES ALASKA, ARIZONA, CALIFORNIA, COLORADO, HAWAII, IDAHO, IOWA (EXCEPT FOR THE ROCK ISLAND ARSENAL AREA), KANSAS, MINNESOTA, MISSOURI (EXCEPT FOR THE ST. LOUIS AREA), MONTANA, NEBRASKA, NEVADA, NEW MEXICO, NORTH DAKOTA, OREGON, SOUTH DAKOTA, THE EXTREME WESTERN PORTION OF TEXAS, UTAH, WASHINGTON AND WYOMING.

HOW LONG DOES PRE-ENROLLMENT TAKE?

- You may start submitting claims immediately

WHERE SHOULD I SEND THE FORMS?

- Fax the forms directly to WPS

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?

- WPS 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

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 claims submission. We request that you complete and return the agreement form, including this cover letter, to our office. *This TRICARE EDI Agreement is for the West Region.* This includes the states of Washington, Oregon, Idaho, Northern and Southern California, Hawaii, Alaska, Wyoming, Montana, North and South Dakota, Utah, Colorado, Nevada, Arizona, New Mexico, Nebraska, Missouri, Iowa, Kansas, Minnesota and the western tip of Texas.

Effective 9/1/2006, if you are a new TRIWEST Network provider, you are not required to complete and return this provider agreement form, as your network agreement includes EDI claims submission language. If you have been a network provider prior to September 1, 2006, we request that you complete and return this Provider Agreement form, including this cover letter, to our office.

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 a 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. In addition to the agreement, the following information is needed (please print):

NPI Organizational Number: ____

NPI Individual Number: ____

Physician/Clinic/Institution Name: ____

Number of Providers within clinic: Network _____ **Non-Network** ____

Will you be billing: Institutional charges _____ **Professional charges** _____ **Both** _____

Contact Name (Full): ____

Phone Number: ________________________ **Fax Number:** ____________________________

Contact E-Mail Address: ____

Provider/Clinic/Institutional Physical Location Address:

____

____

Indicate EDI option:
1) Name of Billing Service/Clearinghouse (if applicable): ___***Office Ally, LLC***_________

2) PC ACE Software: _____ **3.) TriWest.com claim submission** _____

4.) WPS Batch Website Claim Submission _***XXX***_

If you self registered as a submitter through the WPS Trade Partner System (WTPS), please provide the submitter number assigned to you: _________________

**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,

Electronic Data Services
Wisconsin Physicians Service

PROVIDER AGREEMENT TO TRANSMIT
ELECTRONIC MEDIA TRICARE CLAIMS TO
WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION

For purposes of the United States Department of Defense's TRICARE health care program ("TRICARE"), Wisconsin Physicians Service Insurance Corporation (hereinafter referred to as "WPS"), and the undersigned health care provider (hereinafter referred to as "Provider"), acknowledge that each has entered into an agreement concerning the electronic transmission and submission of health claims to WPS and that this agreement is necessary for the implementation of these agreements. The terms set forth herein govern the relationship between WPS and the Provider in their performance of the above referenced agreements.

TERMS AND CONDITIONS

1. In transmitting Electronic Media Claims ("EMC"), Provider will transmit such claims edited and formatted according to the specifications indicated within the most current TRICARE users guide supplied by WPS. Provider understands the WPS EMC users guide is proprietary and is authorized for use only by Provider and its employees working on its behalf to transmit such Electronic Media Claims and that any other use or distribution of the WPS EMC users guide is strictly prohibited without the express written consent of WPS. WPS shall be the final authority in resolving any disputes about how electronic data shall be submitted.

2. Provider agrees that each and every claim submitted via electronic media, for all legal and other purposes, will be considered signed by the Provider or Provider's authorized representative.

3. 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 if no signed authorization is on file, an authorization must be obtained by the Provider from the patient prior to EMC submission to WPS.

4. In accordance with its contract with the TRICARE contractor, WPS will transmit the claims of health care providers in medium and format acceptable to appropriate TRICARE Managed Care Support Contractor and will return reports/electronic remittance from TRICARE Manage Care Support Contractor to the Provider if requested by Provider. WPS may test any transmission against validity and consistency edits as defined in the users guide provided by WPS. Provider understand that WPS will accept all valid claims which meet such edit requirements and return errant transmissions for correction.

5. Provider acknowledges that WPS shall have no obligation with respect to the content of the information in claims either to verify, check or otherwise inspect the information supplied by the health care provider, except to reformat the claim data to the specifications required by the TRICARE Managed Care Support Contractor. Provider further acknowledges that TRICARE Managed Care Support 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 the health care provider.

6. There is no charge per claim to the Provider under this Agreement. WPS reserves the right to charge a per claim fee at a future date but would provide a 60 day notice of this change.

7. This Agreement may be terminated at any time by either party by giving at least five (5) days prior written notice of such termination to the other party. It will terminate automatically at the termination of either of the party's contract with the TRICARE contractor.

8. WPS shall not be liable or deemed in default for failure to fulfill any obligation under this Agreement due directly or indirectly to acts of God or public enemy, civil disorder, fire, flood, strike, or labor dispute, electrical failure, unavailability or shortage of electrical power, severe weather, regulations or acts of governmental agencies or instrumentalities, war or insurrection, mobilization of the armed forces, transportation, postal delay or any other causes beyond WPS' reasonable control.

9. All required and other notices under this Agreement and correspondence with WPS on technical systems matters shall be sent by Provider by certified mail, postage prepaid, return receipt requested to:

   Wisconsin Physicians Service
   Electronic Data Services
   P.O. Box 8128
   Madison, Wisconsin 53708-8128

   If such notice is sent by WPS to the Provider, it will be addressed to the individual at the mailing address listed in the Provider signature space below.

10. This Agreement may not be modified or changed orally. All modifications must be in writing signed by both parties and must be consistent with the parties' obligations under their contracts with TRICARE contractor.

11. The interpretation and legal effect of this Agreement shall be governed by the laws of the State of Wisconsin. The parties agree that any legal proceedings arising out of this Agreement shall be brought in Dane County Circuit Court or United States District Court for the Western District of Wisconsin having jurisdiction over the matter.

12. This Agreement shall be binding upon, and inure to the benefit of the successors, assigns and legal representatives of each of the parties hereto. However, it shall not be assigned by either party without the written consent of the other party; such approval shall not be withheld unreasonably.

13. It is agreed that the relationship of the parties hereto is that of independent contractors and this Agreement does not constitute either party as agent, partner or employee of the other party.

14. WPS will hold harmless, defend and indemnify Provider against any liability, including cost of defense and settlements, imposed on Provider by law for any loss or damage arising from the negligent or intentional acts or omissions of WPS, provided that Provider has not caused such liability by Provider's own negligent or intentional acts or omissions.

    Provider will hold harmless, defend and indemnify WPS against any liability, including cost of defense and settlements, imposed on WPS by law for any loss or damage arising from the negligent or intentional acts or omissions of Provider, provided that WPS has not caused such liability by WPS' own negligent or intentional acts or omissions.

    As a condition to any indemnification hereunder, the indemnified party shall notify the indemnifying party in writing within ten (10) days after receipt of notice of any claim or suit against the indemnified party for which that party seeks indemnification hereunder and failure to so notify the indemnifying party shall relieve the indemnifying party from liability for indemnification. The indemnifying party shall be entitled to make such investigation, settlement or defense of the claim or suit as it deems prudent.

15. 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

____
Tax ID Number of Provider

____

____
Mailing Address

By ____________________________
Signature and Title of Provider or Authorized Officer

____
Date

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION

____

____
NPI Number of Provider

By ____________________________
WPS Authorized Signature

____
Date