Clinic or group practice certification application

(Professional association, corporation, partnership, clinic, etc.)

Request date: _____

Group name: _____ Medicare #: _____

Phone #: _____ Fax #: _____

Federal tax ID #: _____ National Provider Identifier (NPI) #: _____

Clinic office location (street address): _____

City: _____ State: _____ ZIP: _____

Billing address (if different): _____

City: _____ State: _____ ZIP: _____

Corporate name: _____

Corporate address: _____

City: _____ State: _____ ZIP: _____

Date legal entity established: _____

Is your organization certified by Medicare as a CORF, CARF or ORF? ☐ Yes ☐ No Attach a copy of your certification.

How is the purpose of your corporation defined in your Article(s) of Incorporation? Attach a copy of the article defining purpose.

Do you bill only for professional services or facility services such as part day care charges for treatment rooms, etc.?

_____

Are group members all the same specialty? ☐ Yes ☐ No If Yes, name specialty: _____

Please submit: "Request for Taxpayer ID Number and Certification" from the IRS W-9 Form

(1) The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

(2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding [does not apply to real estate transaction, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an individual retirement arrangement (IRA), and payments other than interest and dividends].

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Certification instructions: You must cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

Signature of person completing form:_____ 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 notify us of any changes related to your provider file information (name, address, specialty, tax number, group affiliations, etc.).

Please return application by fax/mail to:

Fax
(608) 221-7535

Mail
TRICARE East Provider Certification
PO Box 7870
Madison, WI 53707-7870

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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: _____

Signature: _____ Specialty and SSN: _____

State license # if required by organization: _____

Name: _____ Title: _____

Signature: _____ Specialty and SSN: _____

State license # if required by organization: _____

Name: _____ Title: _____

Signature: _____ Specialty and SSN: _____

State license # if required by organization: _____

Name: _____ Title: _____

Signature: _____ Specialty and SSN: _____

State license # if required by organization: _____

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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. Please complete the requested information on the authorization form below and return it to our office to assure prompt adjudication of your claims. Thank you.

Authorized signer

Hospital/Clinic name: _____ IRS tax #: _____

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 canceled 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 as follows:

_____

Signature Printed name Official title

_____

Signature Printed name Official title

_____

Signature of president (or authorized officer of the governing body of the hospital, clinic or association) Date

Computer generated facsimile or rubber stamp authorization

Hospital/Clinic name: _____ IRS tax #: _____

National Provider Identifier (NPI) #: _____ Address: _____

City: _____ State: _____ ZIP: _____

_____ being first duly sworn, deposes and says: I hereby authorize Humana Military 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)

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