TRICARE for Life (TFL) serves as TRICARE’s Medicare-wraparound coverage available to all Medicare-eligible TRICARE beneficiaries, regardless of age, provided they have Medicare Parts A and B. WPS encourages your office to take advantage of the benefits that EFT offers.

By enrolling in TFL Electronic Funds Transfer (EFT):

- You will receive quicker payment for services provided to TFL beneficiaries.
- Funds will be deposited directly to your checking or savings account.
- The paper check is replaced eliminating potential delay and inconsistencies with mail procedures.
- Your paper Explanation of Benefits (EOB) will no longer be mailed 45 days after your EFT becomes effective.
- WPS will complete the pre-note process with your bank to ensure a problem-free conversion to EFT for your office once this completed agreement form is received.

**Select the option which best fits your office:**

____ I am already receiving TRICARE for Life Electronic Remittance Advice (ERA).

My receiver ID is: __________

____ I will receive TFL ERA through our clearinghouse.

**Contact your clearinghouse for enrollment procedures. ATTACH the completed ERA enrollment from your clearinghouse to this EFT agreement and mail in together**

____ I will receive TFL ERA directly from WPS to my office.

**Complete the ERA Authorization form by going to the following website: http://www.wpsic.com/edi/pdf/edi_ern_tricare.pdf and/or calling our EDI Marketing Department at 1-800-782-2680 Option 4#, ATTACH your ERA Authorization form to this EFT agreement and mail in together**

____ I choose to register on www.Tricare4u.com to view/print my claim payment information.

**ATTACH this sheet with this option marked then mail in together with the EFT agreement**
INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any TRICARE direct deposits are made.

PART I – REASON FOR SUBMISSION
Indicate if this is a new EFT authorization or change to your existing account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

PART II – IDENTIFICATION DATA
Line 1 – Enter the name of the physician or individual practitioner or the legal business name of the provider/supplier as reported to the Internal Revenue Service (IRS). The account must be solely in the name of the physician or individual practitioner or in the legal business name of the person or entity.
Line 2 – Enter the provider’s/supplier’s legal business name. The account to which EFT payments made must be solely in the name of the physician or individual practitioner or in the legal business name of the person or entity.
Line 3 – Enter the chain organization’s name.
Line 4 – Enter the home office legal business name if different from the chain organization name.
Line 5 – Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.
Line 6 – If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.
Line 7 – Enter the 10 digit NPI number. The NPI is required to process this form.

PART III – DEPOSITORY INFORMATION (Financial Institution)
Line 8 – Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds).
Line 9 – Enter the account holder’s name.
Line 10 – Enter the account holder’s street address.
Line 11 – Enter the account holder’s city, state and ZIP code.
Line 12 – Enter the bank or financial institutional telephone number.
Line 13 – Enter the bank or financial institutional nine-digit routing number.
Line 14 – Enter the depositor’s account number and select the account type.

If you do not submit this information, your EFT authorization agreement will be returned without further processing.

PART IV – CONTACT PERSON
Enter the information for the contact person responsible for this EFT authorization agreement.

PART V – AUTHORIZATION
Line 21 – By your signature on this form you are certifying that the account is drawn in the name of the physician or individual practitioner or in the legal business name of the provider or supplier. The provider or supplier has sole control of the account to which EFT deposits are made in accordance with all applicable regulations and instructions. Arrangements between the depository and the provider or supplier are in accordance with applicable regulations and instructions with the effective date of the EFT authorization. You must notify WPS regarding any changes in the account in sufficient time to allow WPS and the depository to act on changes. The EFT authorization form must be signed and dated by the same Authorized Representative. Mail this form with the original signature (no facsimile signatures can be accepted) to WPS.
WPS TRICARE FOR LIFE ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I – REASON FOR SUBMISSION

Reason for Submission: □ New EFT Authorization
□ Revision to Current Authorization (e.g. account or bank changes)
□ Check here if EFT payment is being made to the Home Office of Chain Organization (Attach letter Authorizing EFT payment to Chain Home Office)
□ EFT Termination Request

PART II – PROVIDER OR SUPPLIER INFORMATION

Name
Provider/Supplier Legal Business Name

Chain Organization Name

Home Office Legal Business Name
(if different from Chain Organization Name)

Tax Identification Number

National Provider Identifier (NPI)

List all physical & billing locations requesting EFT. Attach additional sheet if necessary. Street/City/State/Zip Code

<table>
<thead>
<tr>
<th>Physical Address</th>
<th>Billing Address (Provider Payment Address)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<td>3</td>
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<td>4</td>
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</tbody>
</table>

PART III – DEPOSITORY INFORMATION (Financial Institution)

Depository Name

Account Holder's Name

Account Holder’s Address:
Street

City State Zip

Depository Telephone Number

Depository Contact Person

Depository Routing Transit Number (nine digit)

Depository Account Number

Type of Account (check one) □ Checking Account □ Savings Account

Please include a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type, and, if the information is provided on bank letterhead, a bank officer’s signature. This information will be used to verify your account number.
**PART IV – CONTACT PERSON**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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<tbody>
<tr>
<td>First Name</td>
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<tr>
<td>Middle Initial</td>
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<tr>
<td>Last Name</td>
<td></td>
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<tr>
<td>Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Fax Number (if applicable)</td>
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</tr>
<tr>
<td>Address Line 1 (Street Name and Number)</td>
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<tr>
<td>Address Line 2 (Suite, Room, etc.)</td>
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</tr>
<tr>
<td>City/Town</td>
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<tr>
<td>State</td>
<td></td>
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<tr>
<td>Zip</td>
<td></td>
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<tr>
<td>E-mail Address</td>
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</tr>
</tbody>
</table>

**PART V – AUTHORIZATION**

I hereby authorize Wisconsin Physicians Service Insurance Corporation (hereinafter “WPS”), to initiate credit entries and, in accordance with 31 CFR § 210.6(f), to initiate adjustments for any credit entries made in error to the account identified in Part III, above (hereinafter the "Account"). I hereby authorize the financial institution named in Part III, above (hereinafter the “Depository”), to credit and/or debit the Account.

If payment is being made to an account controlled by a Chain Home Office, I authorize the forwarding of TRICARE for Life payments to the Chain Home Office and acknowledge that this is considered payment to the provider or supplier.

If the account is drawn in an individual's name or the legal business name of the provider or supplier, I certify that the provider or supplier has sole control of the Account and certify that all arrangements between the Depository and the provider or supplier are in accordance with all applicable TRICARE For Life regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until WPS has received written notification from me of its termination at least 30 days in advance as to afford WPS and Depository a reasonable opportunity to act on the notice of termination. WPS will continue to send the direct deposit to the Depository indicated above until notified by me that I wish to change the Depository receiving the direct deposit. If my Depository information changes, I agree to submit to WPS an updated EFT Authorization Agreement.

**Signature Line**

Authorized/Delegated Official Name (Print)

Authorized/Delegated Official Title

Authorized/Delegated Official Signature Date

Return completed form with original signatures to:

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
1717 W. Broadway
Madison, WI 53708-8128
Due to privacy regulations, this request must be submitted by the provider’s office or authorized billing agent.

*Check all that apply:

TRICARE West Region_____ TRICARE For Life_____ TRICARE Overseas_____

The only version of electronic remittance available is 4010A1.

<table>
<thead>
<tr>
<th>GROUP NPI</th>
<th>*PHYSICAL LOCATION</th>
<th>*PAYMENT/ASSOC BILLING LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ________</td>
<td>__________________</td>
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<td>2. ________</td>
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<td>3. ________</td>
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<tr>
<td>4. ________</td>
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</tr>
</tbody>
</table>

If you add an additional service location in the future and wish to receive ERA for this new location, go to our EDI web site at [http://www.wpsic.com/edi/tricare.shtml](http://www.wpsic.com/edi/tricare.shtml) and download another form.

*REQUIRED
ERA REQUESTER INFORMATION

*Requesters Contact Name: _______________________________________________________________

*Requesters Phone #/Email Address: _______________________________________________________

*Provider Authorized Requestor Name: _______________________________________________________

*Authorized Signature: _____________________________________________________________  *Date: ______________________

ERA RECEIVER INFORMATION

Who submits your EDI claims?

Submitter #: ______

Who will be receiving your ERAs?

*Billing Service/Clearinghouse Name: _______________________________________________________

Contact Name: ___________________________________________________________________

Contact Phone#: __________________________________________________________________

Contact Email address: _____________________________________________________________

*Electronic Claim Payment/Advice Receiver # (5 digit # assigned by WPS): __________

If you don’t know your Clearinghouse Receiver ID, contact your Clearinghouse.

If you don’t use a Clearinghouse and you don’t know your submitter ID, Contact WPS.

*Date to begin ERA: __________

Due to HIPAA requirements, only one submitter ID per provider number may be established for ERA. The submitter ID on this request will be the only recipient of ERA for the provider(s) listed.

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

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

Fax (608-) 223-3824

*REQUIRED