



TRICARE for Life Electronic Funds Transfer (EFT) Authorization Form

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)
- Chain Home Office: 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

Physical Address	Billing Address (Provider Payment Address)
1.	
2.	
3.	
4.	

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

First Name	Middle Initial	Last Name
Telephone Number		Fax Number (if applicable)
Address Line 1 (Street Name and Number)		
Address Line 2 (Suite, Room, etc.)		
City/Town	State	Zip
E-mail Address		

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



**TRICARE
PROVIDER AUTHORIZATION FOR WPS
ELECTRONIC REMITTANCE ADVICE**

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.

ERA PROVIDER INFORMATION

*PROVIDER/FACILITY NAME: _____

*PROVIDER/FACILITY TAX ID: _____

List below NPI's and correlating physical location requesting an electronic remittance advice (**attach additional sheet if necessary.**)

<u>GROUP NPI</u>	<u>*PHYSICAL LOCATION</u>	<u>*PAYMENT/ASSOC BILLING LOCATION</u>
1. _____	_____	_____
	_____	_____
	_____	_____
2. _____	_____	_____
	_____	_____
	_____	_____
3. _____	_____	_____
	_____	_____
	_____	_____
4. _____	_____	_____
	_____	_____
	_____	_____

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> 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**



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

Dear TRICARE for Life Provider:

Thank you for choosing electronic submission for your healthcare claims. WPS Insurance Corporation requires that all new electronic providers/groups sign, and have on file, a "Provider Agreement to Submit Electronic Media TRICARE for Life 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 **TRICARE for Life** providers.* "TRICARE For Life (TFL) is TRICARE's Medicare-wraparound coverage available to *all* Medicare-eligible TRICARE beneficiaries, regardless of age, provided they have Medicare Parts A and B."

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 Number:		
Billing Provider Name:		
Claim type (select one or both);	<input type="checkbox"/> Professional	<input type="checkbox"/> Institutional
Contact name:	Phone number:	Fax number:
Contact e-mail address: (Required)		
Service Facility Locations(s):		
<i>NOTE: If you have multiple service facility locations, please attach a list including the associated billing address & NPI for each</i>		

Please specify your EDI submission option:

- Billing service/clearinghouse** (please indicate name: _____)
 - Direct filing using a vendor-supplied EDI software program and transmitting from your site**
- Indicate name of vendor: _____

Indicate submission media: WPS Bulletin Board System WPS-batch Internet submission

If any of the **direct filing** options are selected above, please register as a submitter through the WPS Trading Partner System (WTPS) at <https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do>. If you have already registered as a submitter, please provide the submitter number assigned _____. If you need assistance with registration, please contact WPS Electronic Data Services at 800-782-2680, option 4.

*Please note: A faxed, e-mailed faxed image or original will be accepted. Please mail, fax or e-mail your completed agreement to:

WPS Electronic Data Services
 P.O. Box 8128
 Madison, WI 53708-
Fax: (608) 223-3824
E-Mail: edi@wpsic.com

For Office Use Only

Tax ID. _____, _____, _____,
 Sub # _____ CH _____ Direct _____
 Net after 9/1/06 _____ 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 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.

WISCONSIN PHYSICIANS SERVICE
INSURANCE CORPORATION

Name of Provider

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 _____