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______

Please Note: If you are uncertain which contract(s) will be receiving ERA's, please refer to your TRICARE Provider Handbook which can also be found at http://www.tricare.mil/providers/

The only version of electronic remittance available is 5010A1.

ERA PROVIDER INFORMATION

*PROVIDER/FACILITY NAME: ____

*PROVIDER/FACILITY TAX ID: ____

Please choose only one option below:

______ ***Tax ID*** Choose this option if you want all locations under this Tax Id set up for Electronic Remittance. All Electronic Remits for the Tax ID provided will be sent to the Receiver ID provided on Page 2.

OR

______ ***Specific Practice/Service locations*** Choose this option for specific locations and list them below. All Electronic Remits for the Tax ID and Payment address(s) provided will be sent to the Receiver ID provided on Page 4. Please include **BOTH Physical & Payment Address**.

GROUP NPI	*PHYSICAL ADDRESS	*PAYMENT ADDRESS
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**

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ERA REQUESTER INFORMATION

***Print Provider Authorized Contact/Requestors Name:** ______________________________________*

***Authorized Contact/Requestors Phone# / Email Address:** ___________________________________*

***Authorized Signature:**____ ***Date:** _____________*

ERA RECEIVER INFORMATION

List the Electronic Claim Payment/Advice Receiver Number of your clearinghouse:

Tricare West Region
Receiver Number # _________

Tricare for Life
Receiver Number # _______

Tricare Overseas
Receiver Number # ________

If you don't use a Clearinghouse and receive your ERA's directly, what is your Receiver ID: ________

If you wish to receive ERA's (ANSI 835 file) direct to your office, *if you haven't already*, please register for a trading partner/ERA receiver number at; **https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do**. Place 5 digit assigned trading partner number in the field: __________

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

***Billing Service/Clearinghouse Name**: ____

Contact Name: ____

Contact Phone#: ____

Contact Email address: ____

Date to begin ERA: ___________

______ ***Check if you would like us to turn off your paper Explanations of Benefits (EOB's) after 60 days.***
Note: This applies if you are only receiving ERA. If you are receiving EFT, your EOB's will be shut off automatically after 45 days.

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
EDI@wpsic.com

***REQUIRED**

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WPS® HEALTH INSURANCE