Enrollment in the TRICARE for Life (TFL) EFT will terminate creation of paper Explanation of Benefits (EOB) 45 days after activation.

To obtain your EOB data after 45 days you may:

1. Elect to receive TFL ANSI 835 Electronic Remittance Advice (ERA) and translate it with current practice management system.

2. Elect to receive TFL ERA and translate it with free PC-Ace Pro32 software provided by WPS: (**http://www.wpsic.com/edi/pcacepro32.shtml**)

3. Register on **www.Tricare4u.com** to view/print your claim payment information.

If you choose options 1 or 2 from above please provide information below regarding the scenario which best fits your office:

- If you are currently receiving ERA for TFL, please provide your ERA Receiver ID:

  ____

- If you are currently receiving ERA directly for any other WPS Line of Business and would like to receive your TFL ERA back to this same ERA Receiver ID:

  Please complete the ERA Authorization form (ERA - WPS and TRICARE), selecting 'TRICARE for Life' at the top, and send it along with your EFT Agreement (EFT Agreement must be mailed to maintain the original signature).

- If you do not currently have an ERA Receiver ID or prefer creating a new one for your TFL ERA, you may self register for one at:

  https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do

  ***After registration, be sure to complete the ERA Authorization form (ERA - WPS and TRICARE), selecting 'TRICARE for Life' at the top, and send it along with your EFT Agreement.**

- If you currently submit electronic claims and/or receive ERA for any other WPS Line of Business through a billing service/clearinghouse and would like your ERA to be sent through them, please provide:

  Name of Billing Service/Clearinghouse: ____________________
  Contact Name: ____________________
  Contact Telephone Number: ____________________

  ***Please be sure to follow your Billing Service/Clearinghouse's guidelines for submission of the ERA Authorization form.**

You may contact the EDI Hotline at 1-800-782-2680 (Option #2) for assistance with your registration and/or questions regarding the completion of the ERA Authorization form.

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)

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

1. ____
2. ____
3. ____
4. ____
5. ____

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.

WPS
HEALTH INSURANCE

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

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.