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

Dear TRICARE West Region 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 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 the West Region,* which includes the states of Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming and the western tip of Texas.

Effective 9/1/2006, if you are a new TriWest Network provider, you are not required to complete and return this provider agreement form, as your network agreement includes EDI claims submission language. If you have been a network provider prior to September 1, 2006, we request that you complete and return this Provider Agreement form, including this cover letter, to our office.

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);	☐ **Professional**	☐ **Institutional**
Contact name:		**Phone number:**
Contact e-mail address (Required):		**Fax number:**
Service Facility Location(s):		
NOTE: If you have multiple physical locations, please attach a list including the associated billing address & NPI for each		

Please indicate your EDI submission option:

☐ **Billing service/clearinghouse** (please indicate name): ____

☐ **TriWest.com Internet claim entry**

☐ **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

☐ **Direct filing using *PC-Ace software*** (free claim-entry/submission software supplied by WPS)

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

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For Office Use Only

Tax ID.________________________ ___________ __________, __________ ___________, ___________ ___________,

Sub # _________ CH _______________________ Direct _________ TriWest.com _______ 700 Elig on PDS_____
KMARK _____ ALS _______ App Dt _____________ KMARK ________

Orig Sub # ___________ New Sub # __________ Memo ________ ERAM __________ Initials_________

WPS HEALTH INSURANCE

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 as 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.

____
Name of Provider

____
Tax ID Number of Provider

____
NPI Number of Provider

____

____
Provider Payment Address

By ____________________________
Signature and Title of Provider or Authorized Officer

____
Date

WISCONSIN PHYSICIANS SERVICE
INSURANCE CORPORATION

By ____________________________
WPS Authorized Signature

____
Date

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 Group NPI & Pay To/Payment Location(s)*** Choose this option for a specific group NPI location(s) 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 2. If you have additional locations, please attach. Please include **Pay To/Payment Address.**

GROUP NPI	*PAY TO/PAYMENT ADDRESS
1. ____________	____________________
	____________________
	____________________
2. ____________	____________________
	____________________
	____________________
3. ____________	____________________
	____________________
	____________________
4. ____________	____________________
	____________________
	____________________

If you add an additional Group NPI 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

***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**

TRICARE West Region Electronic Funds Transfer (EFT) Authorization Request

If you are a Network Provider, please select the appropriate REMITTANCE OPTION below, and then *attach* this cover page to the appropriate EFT/ERA Authorization forms and mail to WPS.

By enrolling in **TRICARE West Region** Electronic Funds Transfer (EFT):

- You will receive quicker payment for services provided to **TRICARE West Region** beneficiaries.
- Funds will be deposited directly to your checking or savings account.
- Your paper check is replaced, eliminating potential delay and inconsistencies with mail procedures.

WPS will complete the pre-note process with your bank to ensure a problem-free conversion to EFT for your office once the completed EFT Authorization form is received. **Please note that your paper Explanation of Benefits (EOB) will no longer be mailed 45 days after your EFT becomes effective.**

In order to receive Electronic Funds Transfer for TRICARE claims payments, your office will also need to register to receive Electronic Remittance Advice (ERA) or view your Explanation of Benefits (EOB) and Provider Summary Reports containing payment information on our web site.

Please select your preferred REMITTANCE OPTION from the list below:

____ I am ***already enrolled*** to receive TRICARE West Region ERA, either through my clearinghouse or directly from WPS.

My receiver ID is: __________

*Please **ATTACH** your completed EFT Authorization form to this cover page and mail these documents together to WPS.*

____ I would like to begin receiving **TRICARE West Region ERA** through my clearinghouse.

My receiver ID is: __________

*Please contact your clearinghouse for their specific enrollment procedures. **ATTACH** the completed ERA Authorization from your clearinghouse (or our enclosed ERA document) to the completed EFT Authorization form. Mail each of these documents together with this cover page to WPS.*

____ I would like to begin receiving **TRICARE West Region** ERA from WPS directly to my office.

My receiver ID is: __________

*Please **ATTACH** your completed ERA Authorization form and EFT Authorization form to this cover page and mail these documents together to WPS.*

____ I will register on **www.TriWest.com** to view/print my claim payment information.

*Please **ATTACH** your completed EFT Authorization form to this cover page and mail these documents together to WPS.*

EFT and ERA Authorization forms may also be obtained from the WPS web site: ***http://www.wpsic.com/edi/tools.shtml***

WPS TRICARE WEST REGION 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

List all Group NPI's I & payment locations requesting EFT. Attach additional sheet if necessary. Street/City/State/Zip Code **** If you've attached an ERA Enrollment with this EFT request, we will process the EFT under the same Guidelines unless otherwise specified. This will include all locations under the above Tax ID Number.**

GROUP NPI - (National Provider Identifier)	PAY TO / 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 West Region 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 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.

Original Signature Line

Authorized/Delegated Official Name (Print)

Authorized/Delegated Official Title

Authorized/Delegated Official Original Signature | Date

*Only a **Signed Original** document will be accepted.*

Please, return your completed form(s) 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: Enter the 10 digit Group NPI number. The NPI is required to process this form.
Line 7: Enter the Pay To/Payment locations requesting EFT. Attach additional sheet if necessary. Street/City/State/Zip Code

** **If you've attached an ERA Enrollment with this EFT request, we will process the EFT under the same Guidelines unless otherwise specified.**
Guidelines Listed Below:

1. If you choose the **Tax ID** option on ERA's, and want to receive EFT for the same option, you are giving WPS permission to set up any location currently set up on PDS that is affiliated with this tax id and all NPI's associated with this tax id.
2. If you choose the **Specific** ***Group NPI & Pay To/Payment Location(s)*** for ERA and want to receive EFT for the same option, only the specific pay to/payment locations that you specify will be set up for ERA & EFT. Please add additional sheet if necessary.

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 **Signed Original** 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.