Payer ID: 38520

eSolutions

Tricare North
PGBA
837 and 835

EDI Enrollment Instructions:

- Please save this document to your computer. Open the file in the Adobe Reader program and type directly onto the form.
- For help with filling out the forms, open the attached Instructions.
- Complete a set of forms for each Tax ID.
- Complete the forms using the provider's billing/group information as credentialed with this payer.
- Once completed, save, print and obtain appropriate signature(s).
- EDI enrollment processing timeframe for Tricare is approximately 4 weeks.
- Tricare emails a confirmation notice to the Contact e-mail address.
- To check status of EDI enrollment, please contact Tricare EDI Help Desk at 800-325-5920, Opt 2, Opt 4.

837 Claim Transactions:

Electronic Data Interchange (EDI) Provider Trading Partner Agreement

Not required if you are currently submitting claims electronically.

835 Electronic Remittance Advice:

ERA Enrollment Form for Billing Services and Clearinghouses

Complete as appropriate.

Submit Completed Documents:

1. Fax to Tricare PBGA
   803-264-9864

ELECTRONIC DATA INTERCHANGE (EDI) PROVIDER TRADING PARTNER AGREEMENT

The provider agrees to the following provisions for submitting TRICARE claims electronically to PGBA, LLC.

A. The Provider Agrees:

1. That it will be responsible for all TRICARE claims submitted to PGBA, LLC by itself, its employees, or its agents.

2. That it will not disclose any information concerning a TRICARE beneficiary to any other person or organization, except PGBA, LLC and/or its contractors, without the express written permission of the TRICARE beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to TRICARE, or as required by State or Federal law.

3. That it will submit claims only on behalf of those TRICARE beneficiaries who have given their written authorization to do so, and to certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file. For eligibility transactions, eligibility does not indicate authorization for services. Please follow TRICARE program procedures to obtain authorizations.

4. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:

   - Beneficiary's name,
   - Beneficiary's health insurance claim number,
   - Date(s) of service,
   - Diagnosis/nature of illness, and
   - Procedure/service performed.

5. That the Department of Defense or his/her designee and/or the contractor has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the beneficiary's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable provisions of the, Federal regulations, and TRICARE guidelines.

6. That it will ensure that all claims for TRICARE primary payment have been developed for other insurance involvement and that TRICARE is the primary payer.

7. That it will submit claims that are accurate, complete, and truthful.

8. That it will retain all original source documentation and medical records pertaining to any such particular TRICARE claim for a period of at least 7 years after the bill is paid.

9. That it will affix the PGBA, LLC assigned unique identifier number of the provider on each claim electronically transmitted to the contractor.

10. That the PGBA, LLC assigned unique identifier number constitutes the provider's legal electronic signature and constitutes an assurance by the provider that services were performed as billed.

11. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the TRICARE program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law.

13. That it will establish and maintain procedures and controls so that information concerning TRICARE beneficiaries, or any information obtained from TRICARE or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with S1106(a) of the Act).

14. That it will research and correct claim discrepancies.

15. That it will notify PGBA, LLC within 2 business days if any transmitted data are received in an unintelligible or garbled form.

16. Transmission Format. All standard transactions, as defined by Social Security Act § 1173(a) and the Transaction Rules, conducted between PGBA, LLC and Trading Partner or Business Associate, will only use code sets, data elements and formats specified by the Transaction Rules and the then current version of the PGBA, LLC Supplemental Implementation Guides. The PGBA, LLC Supplemental Implementation Guides and any updates or amendments thereto may be accessed at, www.mytricare.com, and are incorporated herein by reference. This section will automatically amend to comply with any final regulation or amendment to a final regulation adopted by HHS concerning the subject matter of this Section upon the effective date of the final regulation or amendment.

B. PGBA, LLC Agrees To:

1. Provide an acknowledgment of claim receipt. The acknowledgment will consist of a Claims Submission Summary Report and the Error Claims Summary Report. These reports will be provided to the direct submitter of the claims files.

2. Affix the intermediary/carrier number, as its electronic signature, on each remittance advice sent to the provider.

3. Ensure that payments to providers are timely in accordance with TRICARE's policies.

4. Ensure that no contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all TRICARE electronic billers have equal access to any services that TRICARE requires TRICARE contractors to make available to providers or their billing

services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:
Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by Defense Health Agency (DHA) under this document.

This document shall become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as TRICARE claims are submitted to PGBA, LLC. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate.

In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as by the postmark or other appropriate evidence of transmittal.

C. Signature:
I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

I have agreed to the above by signing below on this _____ day of _____, in the year of _____.

_____
Provider Name (Please print)

_____
Provider(s) Tax ID Number

_____
National Provider Identification Number (NPI)

_____
Address

_____
City State Zip Code

_____
Authorized Signature and Title

enrollment@claimremedi.com

_____
Email Address

_____
Contact Name

ClaimRemedi
Billing Service Name/Vendor

422 Larkfield Center #282
Address

Santa Rosa **CA** **95403-1408**
City State Zip Code

Mail or Fax your completed form to:
PGBA, LLC
TRICARE Electronic Data Interchange
P. O. Box 17150
Augusta, GA 30903
Fax: 803-264-9864

Print EDI Form

TRICARE North Region
Electronic Data Interchange
PO Box 17150
Augusta, GA 30903
FAX: 803-264-9864

ERA ENROLLMENT FORM

Provider Information (Required)					
Provider Name (Required)					
Provider Address (Optional)					
Street (R)					
City (R)		State (R)		ZIP Code/ Postal Code (R)	
Provider Identifiers Information (Required)					
Provider Identifiers (R)					
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) (R)					
National Provider Identifier (NPI) (R when provider has an NPI)					
Other Identifiers Assigning Authority (R)		Trading Partner ID (O)	7GW 0376CA3		

☐ **NOTE:** Checking this box indicates enrolling **all** locations for this provider's TIN/EIN that are active in our provider files and will no longer receive a paper remit. Otherwise, if only **specific** locations are to be included, list them below. **Attach additional sheets if necessary**.

TRICARE Provider Number (with suffix)	National Provider Identifier (NPI)	Business Name and Address

Provider Contact Information (Optional)	
Provider Contact Name (R)	
Telephone Number (R)	
Email Address (R when provider has an email address)	

TRICARE North Region
Electronic Data Interchange
PO Box 17150
Augusta, GA 30903
FAX: 803-264-9864

Fax Number (O)	
Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier) **(Required)** (Must match EFT Preference)	
☐ Provider Tax Identification Number (TIN)	
☐ National Provider Identification Number (NPI)	
Method of Retrieval **(Required if provider is not using clearinghouse or vendor)**	Clearinghouse
Electronic Remittance Advice Clearinghouse Information (Optional)	
Clearinghouse Name (R)	ClaimRemedi
Telephone Number (R)	866-633-4726
Email Address (O)	enrollment@claimremedi.com
Reason for Submission **(Required)**	☐ New Enrollment
	☐ Change Enrollment
	☐ Cancel Enrollment
Authorized Signature (Required)	
Electronic Signature of Person Submitting Enrollment (O)	
Printed Title of Person Submitting Enrollment (O)	

Submission Date (O)		Requested ERA Effective Date (O)	

Print ERA Form