



A CELERIAN GROUP COMPANY

**TRICARE West
PGBA, LLC**

Electronic Data Interchange
PO Box 17150
Augusta, GA 30903
Fax: 803-264-9864

Dear Provider:

Thank you for your interest in Electronic Remittance Advice (ERA) with PGBA, LLC. We also offer Electronic Funds Transfer (EFT) which requires a separate enrollment form. If you choose both transactions, you will need to contact your financial institution to arrange for the delivery of the CORE-required minimum CCD+ data elements necessary for successful reassociation of the EFT payment with the ERA remittance advice.

Enclosed is an ERA enrollment form along with instructions for completion. It can also be used to indicate a change or cancellation to an enrollment. Please take the time to review this package thoroughly and follow the instructions and requirements. You also have the option to submit an electronic enrollment for EFT or ERA online at www.TRICARE-West.com. A provider that is not TRICARE authorized or an incomplete form will result in a returned letter to the provider.

Please allow 4 weeks for the enrollment process to be completed. If after 4 weeks you do not start receiving ERA files, you may contact the EDI Help Desk at 800-259-0264 or by email at EDI.TRICARE@PGBA.com.

Once enrolled, ERA files that have not been received after 4 business days of receipt of the corresponding EFT file or check payment can be researched by calling or emailing the EDI Help Desk.

We are committed to making your transition to ERA as smooth as possible. Arrangements can be made for you to receive a paper copy of your remit in conjunction with an 835 transaction file for up to 31 days by contacting the EDI Help Desk. If you have any other questions regarding the information contained in this package, please contact our EDI Help Desk at 800-259-0264 or by email to EDI.TRICARE@PGBA.com.

Once you have completed the enrollment form, **please retain a copy for your records** and mail or fax your completed form to:

**PGBA, LLC
TRICARE Electronic Data Interchange
PO Box 17150
Augusta, GA 30903**

Fax: 803-264-9864

Form Completion Guidelines

Instructions for completing the ERA Enrollment form

- Please type or print legibly.
- Use only black or blue ink to complete paper form.
- Return form to:

PGBA, LLC
TRICARE Electronic Data Interchange
PO Box 17150
Augusta, GA 30903
Fax: 803-264-9864

Provider Information - Please fill out completely

Provider Name - Complete legal name of institution, corporate entity, practice or individual provider.

Provider Address

Street - The number and street name where a person or organization can be found.

City - City associated with provider address field.

State/Province - ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country

Zip Code/Postal Code - System of postal zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery) and exploit electronic reading and sorting capabilities.

Provider Identifiers

Provider Federal Tax Identification Number (TIN) - A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.

National Provider Identifier (NPI) - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Other Identifiers

Assigning Authority – Organization that issues and assigns the additional identifier requested on the form

Trading Partner ID – The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor

Provider Contact Information

Provider Contact Name - Name of a contact in provider office for handling EFT issues

Telephone Number -Associated with contact person

Email Address - An electronic mail address at which the health plan might contact the provider

Fax Number -A number at which the provider can be sent facsimiles

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) -

Provider preference for grouping (bulking) claim payments – must match preference for EFT payment

Must fill out one of the two options below:

Providers Tax Identification Number (TIN)

National Provider Identifier (NPI)

Clearinghouse Information

Clearinghouse Name - Official name of the provider's clearinghouse

Telephone Number – Telephone number of contact

Email Address - An electronic mail address at which the health plan might contact the provider's clearinghouse

Reason for Submission: Must select one from below

New Enrollment

Change Enrollment – write a note stating the needed change and the requested ERA effective date of the change.

Cancel Enrollment – provide requested ERA effective date of the cancellation.

Authorized Signature - The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment may be used with electronic and paper-based manual enrollment

Written Signature of Person Submitting Enrollment - A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity

Printed Name of Person Submitting Enrollment - The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment

Printed Title of Person Submitting Enrollment - The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment

Submission Date - The date on which the enrollment is submitted

Requested ERA Effective Date – Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner

ERA ENROLLMENT FORM

| PROVIDER INFORMATION | | | | |
|--|---------------------------------------|--|-----|--------------------------|
| Provider Name | | | | |
| Street | | | | |
| City | | State | | ZIP Code/ Postal Code |
| PROVIDER IDENTIFIERS INFORMATION | | | | |
| Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) | | | | |
| National Provider Identifier (NPI) | | | | |
| Other Identifiers Assigning Authority | | Trading Partner ID | 7GW | |
| <input type="checkbox"/> 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 | | | | |
| Provider Contact Name | | | | |
| Telephone Number | | Fax Number | | |
| Email Address | | | | |
| Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier) (Must match EFT Preference) | | <input type="checkbox"/> Provider Tax Identification Number (TIN) _____ | | |
| | | <input type="checkbox"/> National Provider Identifier (NPI) _____ | | |
| Method of Retrieval (Required if provider is not using clearinghouse or vendor) | | | | |

| ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION | | | |
|---|---|------------------------------|--|
| Clearinghouse Name | | | |
| Telephone Number | | | |
| Email Address | | | |
| Reason for Submission | <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Enrollment <input type="checkbox"/> Cancel Enrollment | | |
| AUTHORIZED SIGNATURE | | | |
| Electronic Signature of Person Submitting Enrollment | | | |
| Printed Title of Person Submitting Enrollment | | | |
| Submission Date | | Requested ERA Effective Date | |