TRICARE OVERSEAS (FOREN) ERA ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- Electronic Remittance Advice (ERA) Authorization Agreement

WHERE SHOULD I SEND THE FORM(S)?

- Email the form to edi@wpsic.com; OR
- Fax to (608) 223-3824; OR
- Mail to:

  WPS Medicare EDI
  1717 West Broadway
  Madison, WI 53713

HOW DO I CHECK STATUS?

- To check the status of your ERA enrollment, contact WPS at (800) 782-2680 option 2 to verify that your ERAs have been linked to Office Ally's Trading Partner ID 98366.

Instructions for Completing the TRICARE Overseas 835 Electronic Remittance Advice (ERA) Agreement Form

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Information covered below must be followed when completing the form. The ERA Agreement form will be returned if not completed accurately.

DEG1: Provider Information – Required

- **Provider Name:** Complete legal name of the institution, corporate entity, practice or individual provider.
    - If a physician is affiliated with a clinic, please place the Clinic name in the Provider name field. DO NOT put the physician's name. Only include the physician's name if he/she is the practice name or solo practitioner.
- **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 Charter Code associated with the State/Province/Region of the applicable Country
    - **ZIP Code/Postal:** 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.

DEG2: Provider Identifiers Information – Required

- **Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):** A Federal Tax Identification Number, known as an Employer Identification Number (EIN), is used to identify a business entity.
    - TIN or EIN Required
        - Enter nine-digit TIN or EIN.
    - Only one TIN or EIN per form.
- **National Provider Identifier (NPI): Required when provider has been enumerated with an 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 the healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in the lieu of legacy provider identifiers in the HIPAA standards transaction.
    - Enter provider's ten-digit (BILLING/GROUP) NPI number.
    - Only one NPI per form.
- **Other Identifier(s):**
    - Not applicable
- **Assigning Authority:** Organization that issues and assigns the additional identifier requested on the form.
    - Enter the following line of business:
        - TRICARE Overseas
- **Trading Partner ID:** The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor
    - Enter your assigned WPS Trading Partner ID.
    - Only one Trading Partner ID per form.
    - If utilizing a clearinghouse to obtain your 835s, enter your clearinghouse WPS Trading Partner ID.

DEG3: Provider Contact Information – Required

This section is to provide the contact information for the provider only and is not to be used to provide information for any other entity.

DEG4: Provider Agent Information – Optional

DEG5: Federal Agency Information – Optional (Not Used by WPS Health Solutions)

DEG6: Retail Pharmacy Information – Optional (Not Used by WPS Health Solutions)

DEG7: Electronic Remittance Advice Information – Required

- **Provider Tax Identification Number (TIN): Optional – required if NPI is not applicable**
  - Only one TIN or EIN per form.
- **National Provider Identifier (NPI): Optional – required if TIN is not applicable**
  - If a specific NPI is not provided, all NPIs related to the provided Tax ID will be set up using the information provided in this request.
  - Only one NPI per form.
- **Method of Retrieval:** The method in which the provider will receive the ERA from the health plan (e.g., download from the health plan website, clearinghouse, etc.)
  - Required if provider is NOT using a clearinghouse
  - Enter "Direct" if you will NOT be using a clearinghouse.

DEG8: Electronic Remittance Advice Clearinghouse Information – Required if provider is using a Clearinghouse and/or Billing Service or third-party entity to retrieve 835s.

DEG9: Electronic Remittance Advice Vendor Information – Optional

DEG10: Submission Information – Required

- **Reason for Submission**:
  - Choose appropriate reason.
- **Authorized Signature:** The signature of an individual authorized by the provider it its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment.
- **Printed Name of Authorized Representative:** Printed Name of Authorized Representative.
- **Submission Date:** The date on which the enrollment was submitted.
- **Requested ERA Effective Dated:** Date the provider wishes to begin ERA; per Phase II 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.
  - Requested date cannot be 30 days greater than the date of submission.

Electronic Remittance Advice (ERA) Authorization Agreement

This document is intended to establish Electronic Remittance Advice (ERA) enrollment. This document shall become effective when submitted by the provider. The responsibilities and obligations contained in this document will remain in effect as long as claims are submitted to WPS. Either party may terminate this arrangement by giving the other party thirty (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 established by the postmark or other appropriate evidence of transmittal.

DEG1: Provider Information

Provider Name:

Doing Business As Name (DBA):

Provider Address

Street: City: State/Province:

Zip Code/Postal Code: Country Code:

DEG2: Provider Identifiers Information

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):

National Provider Identifier (NPI):

Other Identifier(s)

Assigning Authority: Trading Partner ID: 98366

Provider License Number: License Issuer:

Provider Type: Provider Taxonomy Code:

DEG3: Provider Contact Information

Provider Contact Name:

Title:

Telephone Number: Telephone Number Extension:

Email Address: Fax Number:

DEG4: Provider Agent Information

Provider Agent Name:

Agent Address

Street: City: State/Province:

Zip Code/Postal Code: Country Code:

Provider Agent Contact Name: Title:

Telephone Number: Telephone Number Extension:

Email Address: Fax Number:

DEG5: Federal Agency Information

Federal Program Agency Name:

Federal Program Agency Identifier:

Federal Agency Location Code:

DEG6: Retail Pharmacy Information

Pharmacy Name:

Chain Number:

Parent Organization ID:

Payment Center ID:

NCPDP Provider ID Number:

Medicaid Provider Number:

DEG7: Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data

Provider Tax Identification Number (TIN):

National Provider Identifier (NPI):

Method of Retrieval: Clearinghouse

DEG8: Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name: Office Ally

Clearinghouse Contact Name: Customer Service

Telephone Number: 360-975-7000 opt 1 Email Address: support@officeally.com

DEG9: Electronic Remittance Advice Vendor Information

Vendor Name:

Vendor Contact Name:

Telephone Number: Email Address:

DEG10: Submission Information

Reason for Submission: ◯ New Enrollment ◯ Change Enrollment ◯ Cancel Enrollment

Authorized Signature

Printed Name of Person Submitting Enrollment:

Submission Date: Requested ERA Effective Date:

Please send the completed form via mail, email or fax to:

TRICARE Overseas

WPS Medicare EDI
1717 West Broadway
Madison, WI 53713

Fax:(608) 223-3824
Phone:(800) 782 2680
Option 2

Email TRICARE Overseas:
edi@wpsic.com