

**Tricare West Region – Payer ID CH003
Payer Agreement Instructions**

Are you set up with the Payer?

This enrollment form is for submitters who have completed all necessary arrangements with this payer. Although payer requirements vary, please be sure to:

- Register your NPI with this Payer
- Contract with this Payer, if needed. You must have a valid Provider Identification Number (PIN).

In addition there may be other EDI payer requirements. For more specific information please contact the Payer's Provider Relations Department.

McKesson Requirements

Complete the Exhibit B & Carrier Agreement Tracking Form (CAT Form) and fax to the McKesson EDI Enrollment Department at: 800-633-4763. These forms are included in the next two pages.

- This form is used to update the provider/practice profile with the correct information so that approval can be obtained from the payer for electronic submission.
- This form can also be used if you are making changes to an existing setup for this payer, i.e. change to Provider PIN or NPI.
- Please ensure that any tracking information is included. This is used when contacting the payer for approvals.
- Failure to complete this form and submit to McKesson may delay the processing of this payer with the clearinghouse.
- The Exhibit B & CAT Form does not go to the payer, only to McKesson EDI Enrollment.

Payer Enrollment

- Some payers require original forms.
- If the payer accepts copies, be sure to include all pages of the agreement and verify that they are legible.
- Submit one agreement per Provider Group ID
- Incomplete or incorrect agreements may be denied or returned by the payer and may require the enrollment process be started from the beginning.
- Approvals can take 3 – 4 weeks.

Payer Approvals

- In some cases the payer will send the approval to the provider/practice instead of notifying the clearinghouse. If you receive payer approval please let us know by faxing a copy to EDI Enrollment at: 800-633-4763.
- DO NOT transmit claims to this payer until you have verified with the Enrollment Department that the clearinghouse has received and updated the approval in their system.

Guidelines for completing: Tricare West Region – Payer ID CH003

When you have completed this agreement please mail to the payer at:

Mailing Address:

Electronic Data Services
Wisconsin Physician Service
P.O. Box 8128
Madison, WI 53708

Some states in the West Region have been subdivided into other regions dependant on zip code. Please visit the TRICARE website at <http://www.tricare.osd.mil> for specific zip code divisions.

Page 1 – WPS Cover Letter

Section	Instructions
Physician/ Clinic/ Institution Name:	Name of Practice/ Provider.
Number of Providers within Clinic per Tax ID:	Number of providers associated with practice tax ID.
Contact Name, Phone Number, Fax Number, Contact E-Mail Address:	Complete as indicated.
Physician/ Clinic/ Institution Physical Location Address:	Physical address of Practice/ Provider.

Page 4 – Provider Agreement to Transmit Electronic Media TRICARE Claims to Wisconsin Physicians Service Insurance Corporation

Section	Instructions
Name of Provider	Name of Practice/ Provider.
Tax ID Number of Provider	Tax ID of Practice/ Provider.
Mailing Address	Mailing address of Practice/ Provider.
By: Signature and Title of Provider or Authorized Officer	This agreement must be signed with the original signature of the provider or authorized agent. Please include date signed. Stamped signatures will not be accepted.

Once the Tricare form(s) has been completed and mailed to the payer, please complete the **McKesson Ex. B & CAT Form** and fax to:

McKesson EDI Enrollment

800-633-4763

FAX TO 1-800-633-4763

Each provider in the practice planning to submit health care transactions electronically must be included in this enrollment form. If a provider has more than one office, please complete a separate form for each office.

PLEASE CHECK ONE OF THE BELOW CHOICES

- Add on Provider (Adding Provider to existing McKesson Account)*
- Add on Payer (Adding Payer to a Provider with an existing McKesson account)**
- Update or Change to a Provider’s PIN or Group Number for requested payers.**

*Adding a provider to an account may result in a pricing increase depending on the pricing plan you are currently on. If you are not sure what pricing plan you are on, please contact your Value Added Reseller or the EDI Enrollment Department at 1-800-689-4550

** If adding or changing information regarding an Insurance Carrier/Payer for an existing provider you must also complete the Carrier Agreement Tracking Form (CAT Form) which is page 2 of this document.

Client ID: _____ Practice Tax-ID: _____

Practice Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____ VAR # _____

Telephone: _____ Facsimile: _____

Billing service name: _____ Billing Service Tax

ID: _____ (If applicable) (If applicable)

<i>First Name</i>	<i>Last Name</i>	<i>Credential</i>	<i>Specialty</i>	<i>Individual NPI</i>	<i>Group NPI</i>

Practice Name:	
Practice Tax ID:	

Please include this form with the Exhibit B. Complete this form for each provider in the practice after all agreements have been forwarded to the respective carriers. You may wish to retain a copy of this form for your records.

In the grid below, please enter **ALL** of the requested information for each carrier/payer to enroll. **This is critical information that is required to complete your enrollment process. The clearinghouse cannot contact payers to confirm your approval for electronic transmission without first knowing the date agreements were mailed to them.**

***Please indicate the appropriate Payer ID Number below each payer as indicated in the payer directory. The Phoenix Payer Directory can be found online at http://www.lytec.com/download/Phoenix_Payer_List.pdf for Lytec users or at http://www.medisoft.com/download/Phoenix_Payer_List.pdf for Medisoft users**

Payer	Provider #1	Provider #2	Provider #3
	Name:	Name:	Name:
	Ind NPI:	Ind NPI:	Ind NPI:
	Group NPI:	Group NPI:	Group NPI:
Medicare	Ind #	Ind #	Ind #
	Grp #	Grp #	Grp #
Medicaid	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
BCBS	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
TriCare	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
RR Medicare	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
Other	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
Other	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #

Please note the date on which you sent each carrier agreement to the carrier and the service used to send it (i.e., UPS, FedEx, Airborne Express, etc.) as well as a package tracking number, if applicable.

Carrier/Payer Name	Date Mailed	Service Used	Tracking Number



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

Dear TRICARE 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 organizational number		
NPI individual number		
Physician clinic name		
Providers within clinic	Number of network providers	Number of non-network providers
Claim type (select one or both)	<input type="checkbox"/> Professional <input type="checkbox"/> Institutional	
Contact name		
Contact phone information	Phone number	Fax number
Contact e-mail address		
Provider/clinic/institution physical location address		

Please indicate your EDI submission option:

- Clearinghouse or billing service (indicate name of clearinghouse/billing service) _____
- PC-Ace software
- TriWest.com Internet claim entry
- WPS-batch Internet claim submission

If you self-registered as a submitter through the WPS Trade Partner System (WTPS), please provide the submitter number assigned to you: _____

*Please note: A faxed copy or original will be accepted. Please mail or fax your completed agreement to:

Electronic Data Services
 WPS Insurance Corporation
 P.O. Box 8128
 Madison, WI 53708-8128
Fax (608) 223-3824

Sincerely,
 WPS Electronic Data Services



**PROVIDER AGREEMENT TO TRANSMIT
ELECTRONIC MEDIA TRICARE CLAIMS TO
WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION**

For purposes of the United States Department of Defense's TRICARE health care program ("TRICARE"), Wisconsin Physicians Service Insurance Corporation (hereinafter referred to as "WPS"), and the undersigned health care provider (hereinafter referred to as "Provider"), acknowledge that each has entered into an agreement concerning the electronic transmission and submission of health claims to WPS and that this agreement is necessary for the implementation of these agreements. The terms set forth herein govern the relationship between WPS and the Provider in their performance of the above referenced agreements.

TERMS AND CONDITIONS

1. In transmitting Electronic Media Claims ("EMC"), Provider will transmit such claims edited and formatted according to the specifications indicated within the most current ANSI X12 837 WPS-TRICARE Companion Guide supplied by WPS. Provider understands the WPS EMC Companion Guide is proprietary and is authorized for use only by Provider and its employees working on its behalf to transmit such EMC and that any other use or distribution of the WPS EMC Companion Guide is strictly prohibited without the express written consent of WPS. WPS shall be the final authority in resolving any disputes about how electronic data shall be submitted.
2. Provider agrees that each and every claim submitted via electronic media, for all legal and other purposes, will be considered signed by the Provider or Provider's authorized representative.
3. 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 if no signed authorization is on file, an authorization must be obtained by the Provider from the patient prior to EMC submission to WPS.
4. In accordance with its contract with the TRICARE contractor, WPS will transmit the claims of health care providers in medium and format acceptable to appropriate TRICARE Managed Care Support Contractor and will return reports/electronic remittance to the Provider if requested by Provider. WPS may test any transmission against validity and consistency edits as defined in the WPS-TRICARE Companion Guide provided by WPS. Provider understands that WPS will accept all valid claims which meet such edit requirements and return errant transmissions for correction.
5. Provider acknowledges that WPS shall have no obligation with respect to the content of the information in claims either to verify, check or otherwise inspect the information supplied by the health care provider, except to reformat the claim data to the specifications required by the TRICARE Managed Care Support Contractor. Provider further acknowledges that TRICARE Managed Care Support 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 the health care provider.
6. There is no charge per claim to the Provider under this Agreement. WPS reserves the right to charge a per claim fee at a future date but would provide a 60 day notice of this change.
7. This Agreement may be terminated at any time by either party by giving at least five (5) days prior written notice of such termination to the other party. It will terminate automatically at the termination of either of the party's contract with the TRICARE contractor.
8. WPS shall not be liable or deemed in default for failure to fulfill any obligation under this Agreement due directly or indirectly to acts of God or public enemy, civil disorder, fire, flood, strike, or labor dispute, electrical failure, unavailability or shortage of electrical power, severe weather, regulations or acts of governmental agencies or instrumentalities, war or insurrection, mobilization of the armed forces, transportation, postal delay or any other causes beyond WPS' reasonable control.
9. All required and other notices under this Agreement and correspondence with WPS on technical systems matters shall be sent by Provider by certified mail, postage prepaid, return receipt requested to:

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
Madison, Wisconsin 53708-8128

If such notice is sent by WPS to the Provider, it will be addressed to the individual at the mailing address listed in the Provider signature space below.

10. This Agreement may not be modified or changed orally. All modifications must be in writing signed by both parties and must be consistent with the parties' obligations under their contracts with TRICARE contractor.
11. The interpretation and legal effect of this Agreement shall be governed by the laws of the State of Wisconsin. The parties agree that any legal proceedings arising out of this Agreement shall be brought in Dane County Circuit Court or United States District Court for the Western District of Wisconsin having jurisdiction over the matter.
12. This Agreement shall be binding upon, and inure to the benefit of the successors, assigns and legal representatives of each of the parties hereto. However, it shall not be assigned by either party without the written consent of the other party; such approval shall not be withheld unreasonably.
13. It is agreed that the relationship of the parties hereto is that of independent contractors and this Agreement does not constitute either party as agent, partner or employee of the other party.
14. WPS will hold harmless, defend and indemnify Provider against any liability, including cost of defense and settlements, imposed on Provider by law for any loss or damage arising from the negligent or intentional acts or omissions of WPS, provided that Provider has not caused such liability by Provider's own negligent or intentional acts or omissions.

Provider will hold harmless, defend and indemnify WPS against any liability, including cost of defense and settlements, imposed on WPS by law for any loss or damage arising from the negligent or intentional acts or omissions of Provider, provided that WPS has not caused such liability by WPS' own negligent or intentional acts or omissions.

As a condition to any indemnification hereunder, the indemnified party shall notify the indemnifying party in writing within ten (10) days after receipt of notice of any claim or suit against the indemnified party for which that party seeks indemnification hereunder and failure to so notify the indemnifying party shall relieve the indemnifying party from liability for indemnification. The indemnifying party shall be entitled to make such investigation, settlement or defense of the claim or suit as it deems prudent.

15. 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

Provider Mailing Address

By _____
*Signature and Title of Provider
or Authorized Officer*

Date

WISCONSIN PHYSICIANS SERVICE
INSURANCE CORPORATION

NPI Number of Provider

By _____
WPS Authorized Signature

Date