



P.O. Box 7011 Northridge, Ca 91327-7011 * (818) 368-5501 * www.signatureclaims.net

Provider Sign-up Form Information

Tri-Care West Medicare

Follow instructions on how to fill out these TWO forms.

Fill out page 1 and page 3

Complete, Sign & Mail, FAX or email to:

WPS Electronic Data Services
WPS Insurance Corporation
P.O. Box 8128
Madison, WI 53708-8128
Fax (608) 223-3824
E-Mail Address: edi@wpsic.com



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 Organizational number:		NPI Individual number:	
Billing Provider name:			
Claim type (select one or both);	<input type="checkbox"/> Professional	<input type="checkbox"/> 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:

X Name of Billing Service/Clearinghouse (if applicable): Signature Claims(11753)_____

TriWest.com Internet claim entry

Direct Filing via WPS Bulletin Board System or Internet Batch (using vendor supplied EDI software program and transmitting from your site) **Name of Vendor if Billing direct (if applicable):** _____

- If this option is selected, please register as a submitter through the WPS Trade 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.

PC-Ace software – Free claims submission software supplied by WPS

Please indicate your method of transmission if sending Direct:

_____ **WPS-batch Internet claim submission**

_____ **WPS Bulletin Board System**

*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
 WPS Insurance Corporation
 P.O. Box 8128
 Madison, WI 53708-8128
Fax (608) 223-3824
E-Mail Address: edi@wpsic.com

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For Office Use Only

Tax ID. _____, _____, _____,

Sub # _____ CH _____ Direct _____ TriWest.com _____ 700 Elig on PDS _____

Net after 9/1/06 _____ Access Database _____ ALS _____ App Dt _____

Orig Sub # _____ New Sub # _____ Memo _____ ERAU _____ Initials _____



**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

WISCONSIN PHYSICIANS SERVICE
INSURANCE CORPORATION

Tax ID Number of Provider

NPI Number of Provider

Provider Payment Address

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

By _____
WPS Authorized Signature

Date

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 _____

The only version of electronic remittance available is 4010A1.

ERA PROVIDER INFORMATION

Provider Name: _____

PROVIDER TAX ID: _____

List below NPI's and correlating physical location requesting an electronic remittance advice (**attach additional sheet if necessary.**)

<u>NPI</u>	<u>PHYSICAL LOCATION</u>	<u>ASSOCIATED BILLING LOCATION</u>
1. _____	_____	_____
	_____	_____
	_____	_____
2. _____	_____	_____
	_____	_____
	_____	_____
3. _____	_____	_____
	_____	_____
	_____	_____
4. _____	_____	_____
	_____	_____
	_____	_____

If you add an additional service location in the future and wish to receive ERA for this new location, please contact WPS Electronic Data Services at 1-800-782-2680 or go to our EDI web site at <http://www.wpsic.com/edi/tricare.shtml> and download another form.



ERA REQUESTER INFORMATION

Requesters Contact Name: _____

Requesters Phone #/Email Address: _____

Provider Authorized Requestor Name: _____

Authorized Signature: _____ Date: _____

ERA RECEIVER INFORMATION

Who will be receiving your ERA?

Submitter #: 11753

Billing Service/Clearinghouse Name: Signature Claims

Contact Name: Bill Greenland

Contact Phone#: 818 368-5501

Contact Email address: bill@signatureclaims.net

Electronic Claim Payment/Advice Receiver # (5 digit # assigned by WPS): 11753

Date to begin ERA: _____

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