

TRICARE FOR LIFE (TDDIR) PRE-ENROLLMENT INSTRUCTIONS



WHAT FORM(S) SHOULD I DO?

- TRICARE for life EDI Claims Agreement

WHERE SHOULD I SEND THE FORM(S)?

- Fax form to: (608) 223-3824; or
- Email to: edi@wpsic.com; or
- Mail form to:
WPS Electronic Data Services
P.O. Box 8128
Madison, WI 53708-8128

WHAT IS THE TURNAROUND TIME FOR ENROLLMENT?

- You may start submitting claims immediately.

HOW DO I CHECK STATUS?

- There is no need to check the status; you may start transmitting your claims immediately through Office Ally.

To complete your enrollment follow instructions on the "Note to My Clients Plus users" page and FAX info requested. We will forward to our clearinghouse and notify you by email when your registration is complete.

Note to My Clients Plus Users:

Once you have confirmed with the Insurance Payer your billing NPI/ Provider number is linked to Office Ally, please fax the following information to 888-653-7115.

- **Please label with “My Clients Plus” on top**
- **Provider/Practice Name as pre-enrolled with the Insurance Payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including State if BCBS, Medicare or Medicaid).**
- **The statement “I have verified my Provider ID has been linked to Office Ally with the Insurance Payer”.**
- **Provider email address where you can be notified of setup completion.**
- **For Noridian Pre-Enrollments Please Also Include: Submitter number**

Revised 10/1/2012

TRICARE for Life EDI Claims Agreement



TRICARE4u.com

Dear TRICARE for Life Provider:

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

Thank you for choosing electronic submission for your healthcare claims. Wisconsin Physicians Service Insurance Corporation ("WPS") requires that all new electronic providers/groups sign, and have on file, a TRICARE for Life Claims Agreement ("Agreement") prior to claims submission. We request that you complete and return the Agreement, including this cover letter, to our office. *This TRICARE for Life EDI Claims Agreement is for TRICARE for Life providers.* TRICARE for Life is TRICARE's Medicare-wraparound coverage available to all Medicare-eligible TRICARE beneficiaries, regardless of age, provided they have Medicare Parts A and B.

An organization that has several providers can execute a single Agreement 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 Number:		
Billing Provider Name:		
Claim type (select one or both);	<input type="checkbox"/> Professional	<input type="checkbox"/> Institutional
Contact name:	Phone number:	Fax number:
Contact e-mail address: (Required)		

Please specify your EDI submission option:

- Billing service/clearinghouse** (please indicate name): Office Ally (TPID 98366)
- Online claim submission through Tricare4u.com**
- Direct filing using a vendor-supplied EDI software program and transmitting from your site**
Indicate name of vendor: _____

Indicate submission media: WPS Bulletin Board System WPS-batch Internet submission

If any of the **direct filing** options are selected above, please register as a submitter through the WPS Trading 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.

Please mail, fax or e-mail your completed Agreement, including this cover letter, to:

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

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For Office Use Only

Tax ID. _____, _____, _____, _____

Sub # _____ CH _____ Direct _____ Added to WEPS Trak _____ App Dt _____

Orig Sub # _____ New Sub # _____ ERAM _____ Initials _____



TRICARE for Life EDI Claims Agreement

TERMS AND CONDITIONS

This TRICARE for Life EDI Claims Agreement (this "Agreement") is entered into between the undersigned health care provider ("Provider") and Wisconsin Physicians Service Insurance Corporation ("WPS") and is effective as of the last date it is signed below.

Provider acknowledges that WPS has entered into a subcontract with the Defense Health Agency (DHA) (the "Contractor") and that the terms and conditions set forth below are necessary for the electronic transmission and submission by Provider and WPS of health care transactions with respect to the U.S. Department of Defense TRICARE program.

1. In submitting electronic transactions, Provider will follow the specifications required by the most current version named under the HIPAA Transactions and Code Sets rules. **This Section 1 does not apply to portal entry via TRICARE4u.com.**
2. For claim transactions, Provider agrees that each and every claim submitted via electronic media, for all legal and other purposes, will be considered to be signed by Provider or Provider's authorized representative.
3. For claim transactions, 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 that if no signed authorization is on file, an authorization must be obtained by the Provider from the patient prior to electronic submission to WPS.
4. Provider acknowledges that WPS shall have no obligation with respect to the content of the information in claims to verify, check or otherwise inspect the information supplied by Provider. Provider further acknowledges that WPS 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 Provider.
5. WPS may apply edits as defined in the X12 ASC Implementation Guide or the WPS-TRICARE Companion Guide against any transaction. Provider understands that WPS will accept all valid transactions which meet such edit requirements and return errant transactions for correction. **This Section 5 does not apply to portal entry via TRICARE4u.com.**
6. This Agreement will terminate automatically at the termination of WPS' subcontract with the Contractor. This Agreement may also be terminated at any time by either party by giving five (5) days advance written notice of such termination to the other party.
7. All notices under this Agreement and correspondence with WPS on technical systems matters shall be sent by Provider to:

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

Notice by WPS to Provider will be addressed to the individual named in Provider's signature blank below, and sent to the mailing address shown below for Provider.
8. This Agreement may not be modified or changed orally. All modifications must be in writing signed by both parties and must be consistent with WPS' obligations under its subcontract with the Contractor and with applicable federal law.
9. This Agreement shall be binding upon the successors or assigns of the parties. However, it shall not be assigned by either party without the written consent of the other party; such approval shall not be withheld unreasonably.
10. It is agreed that the relationship of the parties is that of independent contractors. Neither party is acting as the as agent, partner or employee of the other party.

TRICARE for Life EDI Claims Agreement

11. 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