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## Tricare for Life (TDFIC) - WPS Instructions – Professional/Institutional Claims & ERA

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm your EDI account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck to be sure the provider IDs are correct/valid. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Make a copy of the completed enrollment pages.** Note the date and method of submission. Place in a file that can be easily referred to, in case you need to follow up on the edi enrollment request.

**FAX COMPLETED FORMS TO-**

WPS Insurance Corporation, 608-223-3824

### 837- CLAIMS Provider Enrollment (New) or (Change of Service)

If the provider has NOT submitted claims electronically to this payer or if the provider HAS SUBMITTED electronic claims to this payer VIA ANOTHER CLEARINGHOUSE, and they now want to submit via Practice Insight, the provider must complete this form:

#### 1. Provider Agreement to Transmit Electronic Media Tricare Claims To Wisconsin Physicians Service Insurance Corporation (3 pages)

Pg 1- Enter all provider requested information accurate and complete.

**Note:** Complete pg 1 for each group NPI # or billing group. For example, practice with multiple locations and multiple group NPI #'s, all under the same Tax ID #.

Pg 3- Provider or Authorized Officer signature and title required. Tax ID and NPI # also required on this page.

### 835- ERAs Electronic Remittance Request (New) or (Change of Service)

If the provider wishes to authorize Practice Insight to retrieve 835 ERA files, the provider must complete this form:

#### 1. TRICARE - Provider Authorization for WPS Electronic Remittance Advice (2 pages)

Pg 1- Enter all provider requested information accurate and complete.

**Note:** Enter ALL NPI's and correlating physical locations requesting ERAs.

Pg 2- Authorized signature required.

**Additional Notes: EFT SETUP OPTIONAL**

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### ALLOW UP TO 4 WEEKS FOR PROCESSING

*If it has been over 30 days since request was submitted and you have not yet received confirmation of enrollment, contact your reseller or software support vendor for assistance or call WPS edi dept at 1-800-782-2680.*



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

Dear TRICARE for Life 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 for Life 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 **TRICARE for Life** providers.* "TRICARE For Life (TFL) 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 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):

<b>NPI Number:</b>		
<b>Billing Provider Name:</b>		
<b>Claim type (select one or both);</b>	<input type="checkbox"/> <b>Professional</b>	<input type="checkbox"/> <b>Institutional</b>
<b>Contact name:</b>	<b>Phone number:</b>	<b>Fax number:</b>
<b>Contact e-mail address: (Required)</b>		
<b>Service Facility Locations(s):</b>		
<i><b>NOTE: If you have multiple service facility locations, please attach a list including the associated billing address &amp; NPI for each</b></i>		

**Please specify your EDI submission option:**

**Billing service/clearinghouse** (please indicate name): \_\_\_\_\_

**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 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  
 P.O. Box 8128  
 Madison, WI 53708-

**Fax: (608) 223-3824**  
**E-Mail: [edi@wpsic.com](mailto:edi@wpsic.com)**

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**For Office Use Only**

Tax ID. \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,

Sub # \_\_\_\_\_ CH \_\_\_\_\_ Direct \_\_\_\_\_

KMARK \_\_\_\_\_ ALS \_\_\_\_\_ App Dt \_\_\_\_\_

Orig Sub # \_\_\_\_\_ New Sub # \_\_\_\_\_ ERAM \_\_\_\_\_ Initials \_\_\_\_\_



PROVIDER AGREEMENT FOR TRANSMISSION OF  
ELECTRONIC MEDIA TRICARE TRANSACTIONS TO  
WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION

This Provider Agreement for Transmission of Electronic Media TRICARE Transactions to Wisconsin Physicians Service Insurance Corporation (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 a TRICARE Managed Care Support Contractor (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.
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 the 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 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.
6. This Agreement will terminate automatically at the termination of WPS' subcontract with the Contractor.
7. All notices under this Agreement and correspondence with WPS on technical systems matters shall be sent by Provider to:  
  
Wisconsin Physicians Service  
Electronic Data Services  
P.O. Box 8128  
Madison, Wisconsin 53708-8128
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.

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*



# 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 \_\_\_\_\_

Please Note: If you are uncertain which contract(s) will be receiving ERA's, please refer to your TRICARE Provider Handbook which can also be found at <http://www.tricare.mil/providers/>

The only version of electronic remittance available is 4010A1.

## ERA PROVIDER INFORMATION

\*PROVIDER/FACILITY NAME: \_\_\_\_\_

\*PROVIDER/FACILITY TAX ID: \_\_\_\_\_

Please choose which option you'd like Electronic Remittance Advice (ERA) to be set up:

- 1) \_\_\_\_\_ **Tax ID** - Choose this option if you want all locations under this Tax Id set up for Electronic Remittance. All Electronic Remits for the Tax ID provided will be sent to the Receiver ID provided on Page 2.
- 2) \_\_\_\_\_ **Specific Practice/Service locations** - Choose this option for specific locations and list them below. All Electronic Remits for the Tax ID and Payment address(s) provided will be sent to the Receiver ID provided on Page 2. Please include **BOTH Physical & Payment Address**.

<u>GROUP NPI</u>	<u>*PHYSICAL ADDRESS</u>	<u>*PAYMENT ADDRESS</u>
1. _____	_____ _____ _____	_____ _____ _____
2. _____	_____ _____ _____	_____ _____ _____
3. _____	_____ _____ _____	_____ _____ _____
4. _____	_____ _____ _____	_____ _____ _____

If you add an additional service location in the future and wish to receive ERA for this new location, go to our EDI web site at <http://www.wpsic.com/edi/tricare.shtml> and download another form.

\*REQUIRED

## ERA REQUESTER INFORMATION

\*Print Provider Authorized Contact/Requestors Name: \_\_\_\_\_

\*Authorized Contact/Requestors Phone# / Email Address: \_\_\_\_\_

\*Authorized Signature: \_\_\_\_\_ \*Date: \_\_\_\_\_

## ERA RECEIVER INFORMATION

List the Electronic Claim Payment/Advice Receiver Number of your clearinghouse:

Tricare West Region  
Receiver Number # \_\_\_\_\_

Tricare for Life  
Receiver Number # \_\_\_\_\_

Tricare Overseas  
Receiver Number # \_\_\_\_\_

If you wish to receive ERA's (ANSI 835 file) direct to your office. *If you haven't already*, please register for a trading partner/ERA receiver number at; <https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do>. Place 5 digit assigned trading partner number in the field: \_\_\_\_\_

If you don't know your Clearinghouse Receiver ID, contact your Clearinghouse.

\*Billing Service/Clearinghouse Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Phone#: \_\_\_\_\_

Contact Email address: \_\_\_\_\_

Date to begin ERA: \_\_\_\_\_

\_\_\_\_\_ **Check if you would like us to turn off your paper Explanations of Benefits (EOB's) after 60 days**

**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  
[EDI@wpsic.com](mailto:EDI@wpsic.com)

\*REQUIRED



## TRICARE for Life Electronic Funds Transfer (EFT) Authorization Form

**\*\* ATTACH this cover page/sheet with the appropriate option marked, then mail together with the EFT form attached.**

**TRICARE for Life (TFL)** serves as TRICARE's Medicare-wraparound coverage available to all Medicare-eligible TRICARE beneficiaries, regardless of age, provided they have Medicare Parts A and B. WPS encourages your office to take advantage of the benefits that EFT offers.

By enrolling in **TFL** Electronic Funds Transfer (EFT):

- You will receive quicker payment for services provided to **TFL** beneficiaries.
- Funds will be deposited directly to your checking or savings account.
- The paper check is replaced eliminating potential delay and inconsistencies with mail procedures.
- **Your paper Explanation of Benefits (EOB) will no longer be mailed 45 days after your EFT becomes effective.**
- WPS will complete the pre-note process with your bank to ensure a problem-free conversion to EFT for your office once this completed agreement form is received.

**Select the option which best fits your office:**

\_\_\_\_\_ I will receive **TFL** ERA through our clearinghouse.

**My receiver ID is:** \_\_\_\_\_

*\*\*Contact your clearinghouse for enrollment procedures. **ATTACH** the completed ERA enrollment from your clearinghouse to this EFT agreement and/or use our attached document. Once completed, mail in together\*\**

\_\_\_\_\_ I will receive **TFL** ERA (Directly) from WPS to my office.

**My receiver ID is:** \_\_\_\_\_

*\*\*Complete the ERA Authorization form attached or go to the following website:  
[http://www.wpsic.com/edi/pdf/edi\\_ern\\_tricare.pdf](http://www.wpsic.com/edi/pdf/edi_ern_tricare.pdf) and download our WPS ERA Authorization form.*

**ATTACH** your ERA Authorization form to this EFT agreement and mail in together\*\*

\_\_\_\_\_ I choose to register on [www.Tricare4u.com](http://www.Tricare4u.com) to view/print my claim payment information.

**\*\*ATTACH** this sheet with this option marked then mail in together with the EFT agreement\*\*

**Tricare for Life providers are currently not required to submit claims electronically in order to receive ERA and/or EFT. Most of the Tricare for Life claims are electronically crossed from Medicare; however, some are not, such as the beneficiary having a Medicare Advantage Plan. Also, some practice management systems/software requires claim submission in certain situations (i.e. if claim payments are not received within a certain number of days etc.) When these situations occur, WPS encourages you to take advantage of the benefits of electronic claim submission.**

# INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any TRICARE direct deposits are made.

## PART I – REASON FOR SUBMISSION

Indicate if this is a new EFT authorization or change to your existing account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

## PART II – IDENTIFICATION DATA

**Line 1** – Enter the name of the physician or individual practitioner or the legal business name of the provider/supplier as reported to the Internal Revenue Service (IRS). The account must be solely in the name of the physician or individual practitioner or in the legal business name of the person or entity.

**Line 2** – Enter the provider's/supplier's legal business name. The account to which EFT payments made must be solely in the name of the physician or individual practitioner or in the legal business name of the person or entity.

**Line 3** – Enter the chain organization's name.

**Line 4** – Enter the home office legal business name if different from the chain organization name.

**Line 5** – Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.

**Line 6** – If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.

**Line 7** – Enter the 10 digit NPI number. The NPI is required to process this form.

**Line 8** - Enter all physical & payment locations requesting EFT. Attach additional sheet if necessary. Street/City/State/Zip Code

\*\* If you've attached an ERA Enrollment with this EFT request, we will process the EFT under the same Guidelines unless otherwise specified.

## Guidelines Listed Below:

1. If you choose the Tax ID option on ERA's, and want to receive EFT for the same option, you are giving WPS permission to set up any location currently set up on PDS that is affiliated with this tax id and all NPI's associated with this tax id.
2. If you choose the Specific Practice/Service locations for ERA and want to receive EFT for the same option, only the specific practice/service locations that you specify will be set up for ERA & EFT. Please add additional sheet if necessary.

## PART III – DEPOSITORY INFORMATION (Financial Institution)

**Line 9** – Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds).

**Line 10** – Enter the account holder's name.

**Line 11** – Enter the account holder's street address.

**Line 12** – Enter the account holder's city, state and ZIP code.

**Line 13** – Enter the bank or financial institutional telephone number.

**Line 14** – Enter the bank or financial institutional nine-digit routing number.

**Line 15** – Enter the depositor's account number and select the account type.

**If you do not submit this information, your EFT authorization agreement will be returned without further processing.**

## PART IV – CONTACT PERSON

Enter the information for the contact person responsible for this EFT authorization agreement.

## PART V – AUTHORIZATION

**Line 21** – By your **Signed Original** signature on this form you are certifying that the account is drawn in the name of the physician or individual practitioner or in the legal business name of the provider or supplier. The provider or supplier has sole control of the account to which EFT deposits are made in accordance with all applicable regulations and instructions. Arrangements between the depository and the provider or supplier are in accordance with applicable regulations and instructions with the effective date of the EFT authorization. You must notify WPS regarding any changes in the account in sufficient time to allow WPS and the depository to act on changes. The EFT authorization form must be signed and dated by the same Authorized Representative. Mail this form with the original signature (no facsimile signatures can be accepted) to WPS.

**WPS TRICARE FOR LIFE ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT**

**PART I – REASON FOR SUBMISSION**

- Reason for Submission:  New EFT Authorization
- Revision to Current Authorization (e.g. account or bank changes)
- Chain Home Office:  Check here if EFT payment is being made to the Home Office of Chain Organization (Attach letter Authorizing EFT payment to Chain Home Office)
- EFT Termination Request

**PART II – PROVIDER OR SUPPLIER INFORMATION**

Name

Provider/Supplier Legal Business Name

Chain Organization Name

Home Office Legal Business Name  
(if different from Chain Organization Name)

Tax Identification Number

National Provider Identifier (NPI)

List all physical & payment locations requesting EFT. Attach additional sheet if necessary. Street/City/State/Zip Code

Physical Address	Payment Address
1.	
2.	
3	
4	

**PART III – DEPOSITORY INFORMATION (Financial Institution)**

Depository Name

Account Holder's Name

Account Holder's Address:  
Street

City

State

Zip

Depository Telephone Number

Depository Contact Person

Depository Routing Transit Number (nine digit)

Depository Account Number

Type of Account (check one)  Checking Account  Savings Account

Please include a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type, and, if the information is provided on bank letterhead, a bank officer's signature. This information will be used to verify your account number.

**PART IV – CONTACT PERSON**

First Name

Middle Initial

Last Name

Telephone Number

Fax Number (if applicable)

Address Line 1 (Street Name and Number)

Address Line 2 (Suite, Room, etc.)

City/Town

State

Zip

E-mail Address

**PART V – AUTHORIZATION**

I hereby authorize Wisconsin Physicians Service Insurance Corporation (hereinafter "WPS"), to initiate credit entries and, in accordance with 31 CFR § 210.6(f), to initiate adjustments for any credit entries made in error to the account identified in Part III, above (hereinafter the "Account"). I hereby authorize the financial institution named in Part III, above (hereinafter the "Depository"), to credit and/or debit the Account.

If payment is being made to an account controlled by a Chain Home Office, I authorize the forwarding of TRICARE for Life payments to the Chain Home Office and acknowledge that this is considered payment to the provider or supplier.

If the account is drawn in an individual's name or the legal business name of the provider or supplier, I certify that the provider or supplier has sole control of the Account and certify that all arrangements between the Depository and the provider or supplier are in accordance with all applicable TRICARE For Life regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until WPS has received written notification from me of its termination at least 30 days in advance as to afford WPS and Depository a reasonable opportunity to act on the notice of termination. WPS will continue to send the direct deposit to the Depository indicated above until notified by me that I wish to change the Depository receiving the direct deposit. If my Depository information changes, I agree to submit to WPS an updated EFT Authorization Agreement.

**Original Signature Line**

Authorized/Delegated Official Name (Print)

Authorized/Delegated Official Title

Authorized/Delegated Official Original Signature

Date

*Only a **Signed Original** document will be accepted.*

Please, return your completed form(s) with **(ORIGINAL SIGNATURES)** to:

Wisconsin Physicians Service  
Electronic Data Services  
P.O. Box 8128  
1717 W. Broadway  
Madison, WI 53708-8128