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. **Clearinghouse 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** 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** 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: Please choose only one option:

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 *Group NPI & Pay To/Payment Location(s)*** for ERA and want to receive EFT for the same option, only the specific pay to/payment locations that you specify will be set up for ERA & EFT. Please add additional sheet if necessary.

Line 7A: Enter the 10 digit Group NPI number. The NPI is required to process this form.
Line 7B: Enter the Pay To/Payment locations requesting EFT. Attach additional sheet if necessary.

PART III – DEPOSITORY INFORMATION (Financial Institution)
Line 8 – Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds).
Line 9 – Enter the account holder's name.
Line 10 – Enter the account holder's street address.
Line 11 – Enter the account holder's city, state and ZIP code.
Line 12 – Enter the bank or financial institutional telephone number.
Line 13 – Enter the bank or financial institutional nine-digit routing number.
Line 14 – 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** 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.

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)
- ☐ 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

Please choose only one option below:

_____ ***Tax ID*** Choose this option if you want all locations under this Tax Id.

OR

_____ ***Specific Group NPI & Pay To/Payment Location(s)***

Choose this option for a specific group NPI location(s) and list them below. If you have additional locations, please attach. Please include **Pay To/Payment Address.**

GROUP NPI - (National Provider Identifier)	PAY TO / PAYMENT ADDRESS
1.	
2.	
3	

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.

Official Signature Line

Authorized/Delegated Official Name (Print)

Authorized/Delegated Official Title

Authorized/Delegated Official Signature | Date

Please, return your completed form(s) to:

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
1717 W. Broadway
Madison, WI 53708-8128
Fax: 608-223-3824
E-mail: EDI@wpsic.com