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):

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

Please specify your EDI submission option:

☒**Name of Clearinghouse or Billing service** (if applicable): ___Lindsay Technical Consultants, Inc._____

☐ **Direct Filing via WPS Bulletin Board System or WPS Secure-EDI website Internet Batch.**

- 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.

**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 _____

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

Orig Sub # _____ New Sub # _____ Memo _____ ERAU _____ 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.

_____	WISCONSIN PHYSICIANS SERVICE
Name of Provider	INSURANCE CORPORATION
_____	
Tax ID Number of Provider	
_____	
NPI Number of Provider	
_____	
_____	
Provider Payment Address	
By _____	By _____
Signature and Title of Provider or Authorized Officer	*WPS Authorized Signature*
_____	_____
Date	*Date*