Special authorization

I certify that I am an associate with the _____

(Name of clinic association)

whose address is _____

I also certify that I am not an intern or resident, and that I am licensed as indicated in this state (or, if licensing is not required, that I am eligible for membership in the national or state organization setting the standards for my allied science specialty).

I hereby authorize any of the duly authorized representatives of the above-named organization as my agents to submit on my behalf claims for services provided TRICARE beneficiaries, and to receive on my behalf any payments which may be made pursuant to submission of such claims. It is understood and agreed that claims will be submitted only for services which are medically indicated for the proper care of the patient, and the services (where provided by other than a physician or dentist) were ordered by the attending physician or dentist and that the services were actually furnished.

I understand that I may withdraw this authorization at any time by giving written notice of such fact to the above-named organization.

I also agree to hold the United States and its fiscal administrators under TRICARE harmless for any losses that might occur to me as the result of any action on the part of representatives of the above- named organization after payment has been made by the United States or its fiscal administrators to said organizations for services which I have rendered, pursuant to a billing and claim submitted in my behalf in accordance with the terms of this agreement.

I also understand the making or conspiring to make a false, fictitious or fraudulent claim against the United States or one of its fiscal administrators renders such person liable to prosecution under applicable Federal Law.

Name: _____ Title: _____

Signature: _____ Specialty and SSN: _____

State license # if required by organization: _____

Name: _____ Title: _____

Signature: _____ Specialty and SSN: _____

State license # if required by organization: _____

Name: _____ Title: _____

Signature: _____ Specialty and SSN: _____

State license # if required by organization: _____

Please return application by fax to:

(502) 434-6166

Humana Military | TRICARE®

Authorized signer

If a provider elects to use a facsimile signature (rubber stamp) or allow a representative to sign his/her name for certification of the services rendered, it is a TRICARE requirement that we have an authorization from the provider. Please complete the requested information on the authorization form below and return it to our office to assure prompt adjudication of your claims. Thank you.

Hospital/Clinic name: _____ IRS tax #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Each of the below named representatives of this organization are hereby authorized to complete and sign all claim forms required by TRICARE and any related documentation that might be required by fiscal administrators of TRICARE on behalf of all physicians, dentists and other allied science professional staff members for authorized services, care and treatment rendered in the hospital or clinic to TRICARE patients.

The undersigned understands that this is continuing authorization and that the data on such claim forms is entered with the same authority, accuracy and effect as though executed by a member of the professional staff on whose behalf the form is completed. We understand that this authorization shall remain in effect until canceled or modified in writing by the undersigned or our successors in office.

The agents' signatures and typed names and official titles with the organization as authorized above as follows:

_____

Signature Printed name Official title

_____

Signature Printed name Official title

_____

Signature of president (or authorized officer of the governing body of the hospital, clinic or association) Date

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Computer generated facsimile or rubber stamp authorization

Hospital/Clinic name: _____ IRS tax #: _____

National Provider Identifier (NPI) #: _____ Address: _____

City: _____ State: _____ ZIP: _____

_____ being first duly sworn, deposes and says: I hereby authorize Humana Military to accept my facsimile or stamp signature, shown below, as my true signature for all purposes under the TRICARE program in the same manner as if it were my actual signature.

_____ _____

Actual signature Facsimile or stamp signature

Subscribed and sworn to before me this _____ (date) day of _____ (month), 20 _____ .

Notary public in and for _____ county,

state of _____ , my commission expires _____ . (SEAL)

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