Provider Last Name	***Provider First Name and Initial***	***Provider Degree***	I certify that I have arranged for the submission of my claims through the claims clearing-house designated by UMVS **(Y/N)**:	I have elected to submit paper claims to: TRICARE West Region Claims Department, PO box 7064, Camden SC 29020-7064 **(Y/N)**:	**Gender**	**Accept VA? (Y/N)**	**Accept Tricare**	**Accept CHAMP VA? (Y/N)**	**Accept New Patients ? (Y/N)**	**Hospital Based only? (Y/N)**	**PCM Provider? (Y/N)** ***PCM definition: Adolescent Medicine, Family Practice, General Practice, Gynecology, Internal Medicine, Obstetrics, Obstetrics & Gynecology, Pediatrics***	**Is Provider a member of the Reserves? (Y/N)**	**Is Provider a member of the National Guard? (Y/N)**	**office hours**	**Board Certified Yes/No**