

TENNCARE DISCRIMINATION COMPLAINT

Federal and State laws do not allow the TennCare Program to treat you differently because of your **race, color, birthplace, disability/handicap, age, sex, religion, or any other group protected by law**. Do you think you have been treated differently for these reasons? Use these pages to report a complaint to TennCare.

The information marked with a star (*) must be answered. If you need more room to tell us what happened, use other sheets of paper and mail them with your complaint.

1.* Write your name and address.

Name: _____

Address: _____

_____ Zip _____

Telephone: Home: (_____) _____ Work or Cell: (_____) _____

Email Address: _____

Name of MCO/Health Plan:

2.* Are you reporting this complaint for someone else? Yes: _____ No: _____

If Yes, who do you think was treated differently because of their **race, color, birthplace, disability/handicap, age, sex, religion, or any other group protected by law?**

Name: _____

Address: _____

_____ Zip _____

Telephone: Home: (_____) _____ Work or Cell: (_____) _____

How are you connected to this person (wife, brother, friend)?

Name of this person's MCO/Health Plan:

3.* Which part of the TennCare Program do you think treated you in a different way:

Medical Services____ Dental Services____ Pharmacy Services____

Long-Term Services & Supports____ Eligibility Services____ Appeals____

4.* How do you think you were you treated in a different way? Was it your

Race____ Birthplace____ Color____ Sex____ Age____

Disability/Handicap____ Religion____ Other_____

5. What is the best time to talk to you about this complaint?

6.* When did this happen to you? Do you know the date?

Date it started: _____

Date of the last time it happened: _____

7. Complaints must be reported by 6 months from the date you think you were treated in a different way. You may have more than 6 months to report your complaint if there is a good reason (like a death in your family or an illness) why you waited.

8.* What happened? How and why do you think it happened? Who did it? Do you think anyone else was treated in a different way? You can write on more paper and send it in with these pages if you need more room.

9. Did anyone see you being treated differently? If so, please tell us their:

| Name | Address | Telephone |
|------|---------|-----------|
|------|---------|-----------|

10. Do you have more information you want to tell us about?

11.* We cannot take a complaint that is not signed. Please write your name and the date on the line below. Are you the Authorized Representative of the person who thinks they were treated differently? Please sign your name below. As the Authorized Representative, you must have proof that you can act for this person. If the patient is less than 18 years old, a parent or guardian should sign for the minor. **Declaration:** *I agree that the information in this complaint is true and correct and give my OK for TennCare to investigate my complaint.*

(Sign your name here if you are the person this complaint is for) (Date)

(Sign here if you are the Authorized Representative) (Date)

Are you reporting this complaint for someone else but you are **not** the person's Authorized Representative? Please sign your name below. **The person you are reporting this complaint for must sign above or must tell his/her health plan or TennCare that it is okay for them to sign for him/her.** **Declaration:** *I agree that the information in this complaint is true and correct and give my OK for TennCare to contact me about this complaint.*

(Sign here if you reporting this for someone else) (Date)

Are you a helper from TennCare or the MCO/Health Plan assisting the member in good faith with the completion of the complaint? If so, please sign below:

 (Sign here if you are either a helper from TennCare or the MCO/Health Plan) (Date)

It is okay to report a complaint to your MCO/Health Plan or TennCare. Information in this complaint is treated privately. Names or other information about people used in this complaint are shared only when needed. Please mail a signed Agreement to Release Information page with your complaint. If you are filing this complaint on behalf of someone else, have that person sign the Agreement to Release Information page and mail it with this complaint. Keep a copy of everything you send. Please mail the completed, signed Complaint **and** the signed Agreement to Release Information pages to:

HCFA ONCC Phone: 1-615-507-6474 or for free at 1-855-857-1673
 310 Great Circle Road, 4th Flr For free TTY dial/llamar al 711 and ask 1-855-857-1673
 Nashville, TN 37243
 Fax: 1-615-253-2917
 Email: HCFA.fairtreatment@tn.gov

To get free help in another language call one of these numbers:

| | |
|-------------------------------------|----------------|
| العربية (Arabic) | 1-800-758-1638 |
| Bosanski (Bosnian) | 1-800-758-1638 |
| كوردی – بادینانی (Kurdish-Badinani) | 1-800-758-1638 |
| كوردی – سورانی (Kurdish- Sorani) | 1-800-758-1638 |
| Soomaali (Somali) | 1-800-758-1638 |
| Español (Spanish) | 1-800-758-1638 |
| Người Việt (Vietnamese) | 1-800-758-1638 |

TennCare Agreement to Release Information

To investigate your complaint, TennCare and your MCO/Health Plan may need to tell other persons or agencies important to this complaint your name or other information about you.

To speed up the investigation of your complaint, read, sign, and mail one copy of this Agreement to Release Information with your complaint. Please keep one copy for yourself.

- I understand that during of the investigation of my complaint TennCare and _____ (write name of your MCO/Health Plan on the line) may need to tell people my name or other information about me to other persons or agencies. For example, if I report that my doctor treated me in a different way because of my color, my MCO/Health Plan may need to talk to my doctor.
- You do not have to agree to release your name or other information. It is not always needed to investigate your complaint. If you do not sign the release, we will still try to investigate your complaint. But, if you don't agree to let us use your name or other details, it may limit or stop the investigation of your complaint. And, we may have to close your case. However, before we close your case if your complaint can no longer be investigated because you did not sign the release, we may contact you to find out if you want to sign a release so the investigation can continue.

If you are filing this complaint for someone else, we need that person to sign the Agreement to Release Information. Are you signing this as an Authorized Representative? Then you must also give us a copy of the documents appointing you as the Authorized Representative.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to TennCare telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to my MCO/Health Plan telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

This Agreement to Release Information is in place until the final outcome of your complaint. You may cancel your agreement at any time by calling or writing to TennCare or to your MCO/Health Plan without canceling your complaint. If you cancel your agreement, information already shared cannot be made unknown.

Signature: _____ Date: _____

Name (Please print): _____

Address: _____

Telephone: _____

Need help? Want to report a complaint? Please contact or mail a completed, **signed Complaint and a signed Agreement to Release Information** form:

HCFA ONCC Phone: 1-615-507-6474 or for free at 1-855-857-1673
310 Great Circle Road, 4th Floor For free TTY dial/llamar al 711 and ask for 855-286-9085
Nashville, TN 37243
Fax: 1-615-253-2917
Email: HCFA.fairtreatment@tn.gov

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