

**TENNCARE
PROVIDER REFUND
REQUEST**



SEND THIS COMPLETED FORM TO:

State of Tennessee
Bureau of TennCare, Floor 4 East
Attention: Accounting
310 Great Circle Road
Nashville, TN 37243-1700
or
Fax # (615)532-3479 Attn: Refunds

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

Form to be completed by a Provider for services rendered that were billed by and paid to the State of TN Bureau of TennCare: If the Provider has money recouped by an MCO for TPL, and upon billing the TPL (Primary Insurance) was told claim has already been processed and payment (check) sent to State of TN, Bureau of TennCare, P.O. Box 305133, Nashville, TN, 37203.

Provider Information:

Provider Name _____

Street Address _____

City _____ State _____ Zip _____

Billing Address _____

City _____ State _____ Zip _____

Contact Name _____ Contact Phone (_____) _____

Contact Fax # (_____) _____ Contact Email _____

TN Medicaid Provider Number _____ NPI _____

Tax Identification Number _____

Member Information:

Patient/Member Name _____

TennCare MCO Name _____ Member ID# _____

SSN _____ DOB ____/____/____ Date of Service ____/____/____

Charges \$ _____ Amount Recouped \$ _____ Date Recouped by MCO ____/____/____

TPL/Primary Insurance Information: (Provide as much information as possible to expedite processing)

TPL (Primary Insurance) Name _____ Member ID# _____

Amount paid to TennCare \$ _____ Check # _____ Check Date ____/____/____

Total Check Amount \$ _____ Date Check Cleared ____/____/____
{Attach copy of check if able to obtain from the TPL Carrier}

Refund Information:

Dollar Amount Due Provider to be refunded by State of TN Bureau of TennCare \$ _____

Brief Description of Situation: _____

Where to Mail Refund:

Mail to Attention of: _____

Mail to Address: _____

City: _____ State: _____ Zip: _____

Provider Attestation:

I hereby certify that the information provided above is correct and that Provider is due amount indicated.

Signature _____ Date ____/____/____

****NOTE: COPY OF TENNCARE MCO RECOUPMENT EOB MUST BE ATTACHED TO THIS FORM****

[Refund request may take up to 45 days to be completed]

TennCare Internal Use Only Below

Date Request Completed: ____/____/____ Initials of Fiscal Agent: _____