TENNCARE PROVIDER REFUND REQUEST

SEND THIS COMPLETED FORM TO:
State of Tennessee
Division 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
DIVISION 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 Division 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, Division 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: ____

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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: _______________