TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION

HCBS ENROLLMENT FOR CURRENTLY CONTRACTED TENNCARE PROVIDERS

EXPRESS APPLICATION

http://www.tennessee.gov/tenncare/pro-forms.html

LIST ALL EXISTING PROVIDER TYPES AND CORRESPONDING NUMBERS:

_______________ _______________ _______________

_______________ _______________ _______________

Legal Business Name: ____

D/B/A: ____

Practice Location: ____
(No P.O. Box #)

City: ______________________ State: ____________ Zip Code + 4: __________

Telephone: ________________ Fax: ________________ County: _____________

Application Surety Statement:

I certify that the information provided on this Express Application is complete and correct to the best of my knowledge. Further, I certify that I am currently and actively participating in the Tennessee Medicaid (TennCare) program as a service provider and have on file with the Bureau of TennCare a completed Application, Provider Participation Agreement and all documentation required for the provider type(s) listed above. I agree to comply with the HCBS Waiver and all federal and state laws, rules and policies governing the Program. This Express Application neither replaces nor amends any previous documents filed to obtain Enrollment as any Provider Type other than HCBS.

Signature: ________________________________ Date: ________________________

Printed Name: _____________________________ Title: _______________________