

**BlueCare/TennCareSelect  
Financial Responsibility For The Cost of Services**

\_\_\_\_\_  
Member Name (Print)

\_\_\_\_\_  
Member ID Number

\_\_\_\_\_  
Service(s) requested

I know BlueCare, TennCare*Select*, Medicare and Medicaid insurance pays for health care. I know when I get health care; my doctor sends the charges to my insurance company for payment. I know I must show my ID card to all doctors and hospitals before I get health care. I know a copayment is when I have to pay part of the bill each time I get certain health care services.

**Please initial each statement listed below that applies to you:**

- \_\_\_\_\_ I do not have TennCare (BlueCare, TennCare*Select*) insurance. I have not tried to get TennCare insurance.
- \_\_\_\_\_ I have BlueCare or TennCare*Select* insurance. I asked for the health care service(s) listed above. I understand my insurance may not pay for it.

My doctor has told me how much of the health care service(s), listed above, I have to pay for. By signing this paper, I agree to pay for the services listed above.

\_\_\_\_\_  
Print the Name of the Responsible Person

\_\_\_\_\_  
Signature of Member or Responsible Person

\_\_\_\_\_  
Date

**For Office Use Only**

Disclaimer: This form is valid only when signed by the member and a TennCare eligibility search has been performed.

**NOTE:** The Financial Responsibility For The Cost of Services form cannot be used if the Member is receiving treatment in the Emergency Room for non-emergent services. This form should be used when the member does not have TennCare coverage or the requested service(s) are not covered by BlueCare or TennCare*Select*, i.e., body piercing, exercise equipment, etc.