



Verification of TennCare Eligibility

Please Fax This Form To 1-866-504-6356

Date Faxed:				Provider Fax Number:					
	Doctor/Facility Name	Provider Number	Member Name	Member Identification Number	Effective Date	Termination Date	Assigned Primary Care Practitioner	Copayment Amount	Medicaid/Standard
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Disclaimer: *These benefits are based on the information provided to TennCareSelect by the Bureau of TennCare. Due to possible contract changes or policy cancellation, final determination will be made when claims are received. This information is subject to change based on eligibility and is ultimately to be determined by the State.*

Signature:	Date:
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Last updated May 2009