

**Note:** If the following information isn't complete, correct or legible, it may delay processing of claims.  
Please use one form per member.

## Member Information (Required)

Member Name: \_\_\_\_\_

Member ID Card Number: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_

## Provider Information (Required)

Provider Name: \_\_\_\_\_

NPI #: \_\_\_\_\_ DEA#: \_\_\_\_\_

Specialty: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Office Street: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Is the prescriber a TennCare provider with a Medicaid ID? Yes No

Service Requested: \_\_\_\_\_

Based on my professional judgment, I certify that the services to be provided to the individual listed above, including the provision of any hormone or puberty blockers and/or surgical services, are provided in compliance with any and all applicable state and federal laws to which the member, provider, and/or the services provided may be subject.

**Provider Signature (Required):** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/20 \_\_\_\_

*(By signing, the provider confirms the above information is accurate and verifiable by patient records.)*

Please attach relevant clinical information to this form. Fax the completed form and clinical information to the appropriate fax number for your patient's plan:

- › Commercial Pharmacy Utilization Management: **1-888-343-4232**
- › Commercial Medical Utilization Management: **1-866-558-0789**
- › Federal Employee Plan: **1-800-495-1944**

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