TennCare Authorization of Representative Organization

You must complete this form if you want an **ORGANIZATION** to represent you and act on your behalf in applying for medical benefits and/or act for you on an ongoing basis regarding medical coverage from the State of Tennessee, Division of TennCare. This includes programs such as TennCare Medicaid, CHOICES, CoverKids and emergency medical services (EMS). Both you and a member of the organization must sign and date this form.

Applicant/Recipient

Name of Applicant/Recipient (Last, First, Middle Initial):	Phone Number:
ID Number (SSN):	Date of Birth (MM/DD/YYYY):
Address:	City, State and Zip Code:

Scope of Authorization

I understand and voluntarily agree that my Representative Organization is authorized to:

- Obtain from TennCare and submit to TennCare information about me with respect to my general and financial circumstances and medical condition;
- Complete, sign and submit an application and related documents on my behalf;
- Receive information regarding the status of my application and eligibility;
- Receive all notices or other communications regarding my application, appointments, redetermination or eligibility status;
- Accompany me or represent me for any required interview, hearing or appeal;
- Pursue the appeal process, up to and including legal proceedings, in the event my application is denied;
- Act on my behalf in all other matters related to my eligibility determination.

Medical Information

- I voluntarily authorize and request disclosure by TennCare of all my medical information to my Representative Organization and its employees for the purpose of assisting me with the eligibility determination process and other related functions listed above.
- I understand this may include information regarding medication I take now or have taken in the past and may include facts regarding my health and/or present or past alcohol or drug treatment. It does not include psychotherapy notes that are not in my medical records.
- I understand my eligibility and ability to obtain health care and coverage does not depend on my granting this authorization.
- I understand that information shared by my Representative Organization may be shared with others. Not everyone has to follow privacy rules.
- My authorization for TennCare to release medical information to my Representative Organization expires as described below in “Termination of Authorization” or as designated in “Signature of Applicant/Recipient.”

Puede obtener estas hojas en español. Visite nuestro sitio web en www.tennessee.gov/tenncare. O bien, llame TennCare Connect al 855-259-0701.

Termination of Authorization

You can terminate this authorization at any time by calling TennCare Connect at 855-259-0701. Or by giving TennCare written notice that your Representative Organization is no longer authorized to act on your behalf. This will not change facts we have already shared with your Representative Organization, but we won't share any more facts.

Signature of Representative Organization Employee

The authorized Representative Organization understands it is expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time. The Representative Organization agrees to protect and maintain the confidentiality of any information provided to it, including individually identifiable health information and financial information of the applicant, pursuant to the regulations set forth in 42 CFR 435.923; 42 CFR 431 subpart f; 45 CFR 155.260(f), 42 CFR 447.10, as well as other relevant state and federal laws. The Representative Organization also agrees to promptly provide to the Applicant/Recipient copies or originals of all relevant documents, communications and mailing enclosures received from TennCare related to the purposes specified in this authorization.

Organization Name:	
Address:	City, State and Zip Code:
Organization Type (Eligibility Assistance Company, Institution):	
Name of Organization Authorized Employee:	Title:
Email:	Phone Number:
Signature of Organization Authorized Employee:	Date:

Signature of Applicant/Recipient

I authorize this Representative Organization to act for me regarding eligibility and related functions listed above. I understand that I am responsible for the information anyone acting as my authorized representative gives and I may be required to cooperate further, including providing information and documents. I understand that I can terminate this authorization at any time by giving TennCare written notice that my Representative Organization is no longer authorized to act on my behalf. I also understand that my Representative Organization can withdraw as my representative at any time by notifying TennCare in writing and shall also notify me in writing of such withdrawal.

I understand that the Organization may receive payment from my healthcare provider, such as a hospital where I received treatment, to provide these assistance services on my behalf. I understand that the outcome of any eligibility determination regarding my application cannot be guaranteed by the Representative Organization.

I authorize this Representative Organization to help me for: (please check one)

☐ 3 Months ☐ 5 Months ☐ 1 Year ☐ Ongoing; and starting the date listed below.

Signature of Applicant/Recipient:	Date:

If applicant/recipient is not able to sign, an authorized representative may sign and provide legal documentation of authority (e.g. power of attorney, custody documentation).

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