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STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION

DIVISION OF TENNCARE
310 Great Circle Road
NASHVILLE, TN 37243

THIRD PARTY LIABILITY UPDATE FAX REQUEST

TO: TPL Coordinator

Fax Number: **(615) 734-5113**

Today's Date: _____ Number of Pages: _____

Provider Name: _____

Provider Address: _____

_____ TN _____

Provider Phone: _____

Contact Name: _____ Contact Number: _____

Recipient Name: _____ DOB (Date of Birth): _____

SSN: _____ Medicaid Recipient ID#: _____

Relationship to Policy Holder:

◯ Self ◯ Spouse ◯ Dependent

Policy Holder:

Name: _____ SSN: _____

☐ This Insurance Carrier Coverage Needs to be Terminated - TERM DATE: _____

OR

☐ This Insurance Carrier Coverage Needs to be Added - EFFECTIVE DATE: _____

Insurance Carriers Name: _____

Policy Number: _____ Group Number: _____

Credible Coverage Letter Attached? ◯ Yes ◯ No

If this is a Medicare Policy, select the appropriate Medicare Policy type; otherwise select Not Applicable.

◯ Advantage Plan ◯ Supplemental Plan ◯ Not Applicable

REMARKS:
(Limited to 500 Characters)

***All information requested on this form is required. Incomplete forms will not be processed.**

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