STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE
NASHVILLE, TENNESSEE 37202-1700

THIS FORM MUST BE ATTACHED TO EACH CLAIM FORM WITH A TPL EOB.

TPL Carrier Name: _____

Patient Name: _____

Date of Service: _____

TPL Paid Amount (including $0.00) $_____

Signature: _____ Date: _____