

# Having problems getting health care or medicine in TennCare?

Use this page **only** to file a  
**TennCare Medical Appeal.**

**Need help filing a medical appeal?**

Call **1-800-878-3192** for free.

Fill out **both** pages. These are **facts we must have to work your appeal**. If you don't tell us all the facts we need, we may not be able to decide your appeal. You may **not** get a fair hearing. Need help understanding what facts we need? Call us for free at **1-800-878-3192**. If you call, we can also take your **appeal by phone**.

## 1. Who is the person that wants to appeal?

Full name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Or number on their TennCare card \_\_\_\_\_

Current mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

The name of the person we should call if we have questions about this appeal: \_\_\_\_\_

A daytime phone number for that person ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

## 2. Who filled out this form?

If **not** the person that wants to appeal, tell us your name. \_\_\_\_\_

Are you a: \_\_\_\_\_ Parent, relative, or friend \_\_\_\_\_ Advocate or attorney \_\_\_\_\_ Doctor or health care provider\*

(\*You need your patient's written permission to file this appeal. See the third page.)

## 3. What is the appeal for? (Place an **X** beside the right answer below.)

\_\_\_ Want to **change health plans**. (Fill out **Part A** on page 2.)

\_\_\_ **Need care or medicine**. (Fill out **Part B** on page 2.)

\_\_\_ Have **bills or paid for care or medicine** you think TennCare should pay. (Fill out **Part C** on page 2.)

## 4. Do you think you have an emergency?

Usually, your appeal is decided within **90 days** after you file it. But, if you have an emergency and your health plan agrees that you do, you will get an **expedited** appeal. An expedited appeal will be decided in about one week. It could take longer if your health plan needs more time to get your medical records. An emergency means that waiting 90 days for a "yes" or "no" decision **could put your life or physical or mental health in real danger**.

**Do you still think you have an emergency?** If so, you can ask TennCare for an **expedited** appeal by calling 1-800-878-3192. Your **doctor** can also ask for this kind of appeal for you. But the law requires your doctor to have **your permission (OK) in writing**. Write **your name, your date of birth, your doctor's name, and your permission for them to appeal for you** on a piece of paper. Then fax or mail it to TennCare (see **There are 3 ways to file an appeal** for our address and fax number). What if you don't send us your OK and your doctor asks for an expedited appeal? TennCare will send you a page to fill out, sign and send back to us.

After you give your OK in writing, your doctor can help by completing a "Provider's Expedited Appeal Certificate". Your doctor can get the page from TennCare's website. **Go to [tn.gov/tenncare](http://tn.gov/tenncare)**. Click "Providers," and then click "Miscellaneous Provider Forms." Your doctor should fax this certificate and your medical records to TennCare. TennCare **and** your health plan will then look at your appeal and decide if it should be expedited. **If it should be**, you will get a decision on your appeal in about one week. Remember, it could take longer if your health plan needs more time to get your medical records.

**5. Tell us why you want to appeal** this problem. Include any mistake you think TennCare made. And, send copies of any papers that you think may help us understand your problem.

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To see which Part(s) you should fill out below, look at number **3** on page 1.

**Part A. Want to change health plans.** Name of health plan you want \_\_\_\_\_

**Part B. Need care or medicine.** What kind - be specific \_\_\_\_\_

- What's the problem?     \_\_\_ Can't get the care or medicine at all.  
                                  \_\_\_ Can't get as much of the care or medicine as I need.  
                                  \_\_\_ The care or medicine is being cut or stopped.  
                                  \_\_\_ Waiting too long to get the care or medicine.

Did your doctor prescribe the care or medicine? \_\_\_ Yes \_\_\_ No If yes, doctor's name \_\_\_\_\_

Have you asked your health plan for this care or medicine? \_\_\_ Yes \_\_\_ No If yes, when? \_\_\_\_\_

What did they say? \_\_\_\_\_

Did you get a letter about this problem? \_\_\_ Yes \_\_\_ No If yes, the date of the letter \_\_\_\_\_

Who was the letter from? \_\_\_\_\_

**Are you getting this care or medicine from TennCare now?**     \_\_\_ Yes \_\_\_ No

Do you want to see if you can keep getting it during your appeal?     \_\_\_ Yes \_\_\_ No

Does your doctor say you still need it? \_\_\_ Yes \_\_\_ No If yes, doctor's name \_\_\_\_\_

If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

**Part C. Bills for care or medicine you think TennCare should pay for**

The date you got the care or medicine \_\_\_\_\_ Name of doctor, drug store, or other place that gave you the care or medicine \_\_\_\_\_ Their phone number ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Their address \_\_\_\_\_

Did you **pay for the care or medicine and want to be paid back?** \_\_\_ Yes \_\_\_ No

If yes, you must send a copy of a **receipt** that proves you paid for the care or medicine.

If you didn't pay, **are you getting a bill?** \_\_\_ Yes \_\_\_ No If yes, and you think TennCare should pay, you must send a copy of a **bill**. Tell us the date you first got a bill (if you know). \_\_\_\_\_

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**How to file your medical appeal**

**Make a copy of the completed pages** to keep.

Then, **mail** these pages and other facts to:

TennCare Solutions  
P.O. Box 593  
Nashville, TN 37202-0593

Or, **fax** it (toll-free) to 1-888-345-5575. **Keep a copy** of the page that shows your fax went through.

To appeal by **phone**, call 1-800-878-3192 for free.

Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

**We do not allow unfair treatment in TennCare.**

No one is treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability.

If you think you've been treated unfairly, call TennCare Connect for free at **1-855-259-0701**.



STATE OF TENNESSEE  
DIVISION OF TENNCARE  
**TennCare Solutions Unit**  
P.O. Box 000593  
Nashville, Tennessee 37202-0593

### Appeal Authorization Form

**Patient's Printed Name** \_\_\_\_\_

**Patient's Date of Birth** \_\_\_\_\_

**Doctor's Printed Name** \_\_\_\_\_

Yes, I would like to request a Fair Hearing from TennCare for

\_\_\_\_\_  
(Drug, item, or service)

I give my doctor permission to file a fair hearing request on my behalf.

I want to keep getting the services I've been getting until my appeal is over. I understand that my health plan will look at my case and decide if I can keep getting this care during my appeal.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Phone Number**