State of Tennessee
Bureau of TennCare

TennCare Subrogation Interest Identification Inquiry

This completed form must be accompanied by a *HIPAA-compliant Release Form*

Please allow 10 business days for an initial response and
up to a maximum of 120 days for a complete response. TCA § 71-5-117(g)

1. *PATIENT INFORMATION:*

FULL NAME: _____

DATE OF BIRTH: _____ SSN: __ __ __ - __ __ - __ __ __ __

TennCare or MCO ID#: _____ MCO Name: _____

2. *ACCIDENT or ILLNESS INFORMATION:*

DATE of ACCIDENT or ILLNESS: _____LAST DATE of TREATMENT_____

WHERE DID THE ACCIDENT or ILLNESS OCCUR? _____

Please provide a brief description of the PATIENT'S injuries or illness:

_____

_____

_____

Did the PATIENT receive medications or dental treatment as a result of the injury or illness? (Please circle)

If the PATIENT was involved in an ACCIDENT please identify the TYPE of INJURY (Check One)

☐ **Auto** ☐ **Medical Malpractice** ☐ **Worker's Compensation**
☐ **General Liability** ☐ **Other** _____

3. *PERSON COMPLETING THIS FORM:*

Name: _____

Relationship to PATIENT (attorney, guardian, spouse, etc.): _____

Company or Firm: _____

Address: _____

Phone: _____ Fax: _____

Please submit *this completed form* and a *HIPAA-compliant Release Form* according to the INSTRUCTIONS FOR FILING