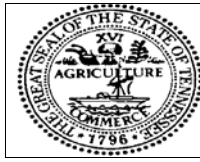


**MEDICAID RECLAMATION  
CLAIM PROVIDER  
REFUND REQUEST FORM**



STATE OF TENNESSEE  
BUREAU OF TENNCARE

**SEND THIS COMPLETED FORM TO:**

State of Tennessee  
Bureau of TennCare, Floor 4 East  
Attention: Fiscal Budget  
310 Great Circle Road  
Nashville, TN 37243-1700  
or  
Fax # 615-532-3479 Attn: Refunds

**Form to be completed by a Provider for services rendered that were billed by and paid to the State of TN Bureau of TennCare: If the Provider has money recouped by an MCO for TPL, and upon billing the TPL (Primary Insurance) was told claim has already been processed and payment (check) sent to State of TN, Bureau of TennCare, P.O. Box 305133, Nashville, TN, 37203.**

**Provider Information:**

Provider Name \_\_\_\_\_

Street Address \_\_\_\_\_

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

Billing Address \_\_\_\_\_

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

Contact Name \_\_\_\_\_ Contact Phone (\_\_\_\_) \_\_\_\_\_

Contact Fax # (\_\_\_\_) \_\_\_\_\_ Contact Email \_\_\_\_\_

TN Medicaid Provider Number \_\_\_\_\_ NPI \_\_\_\_\_

Tax Identification Number \_\_\_\_\_

**Member Information:**

Patient/Member Name \_\_\_\_\_

TennCare MCO Name \_\_\_\_\_ Member ID# \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Service \_\_\_\_/\_\_\_\_/\_\_\_\_

Charges \$ \_\_\_\_\_ Amount Recouped \$ \_\_\_\_\_ Date Recouped by MCO \_\_\_\_/\_\_\_\_/\_\_\_\_

**TPL/Primary Insurance Information:** (Provide as much information as possible to expedite processing)

TPL (Primary Insurance) Name \_\_\_\_\_ Member ID# \_\_\_\_\_

Amount paid to TennCare \$ \_\_\_\_\_ Check # \_\_\_\_\_ Check Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Total Check Amount \$ \_\_\_\_\_ Date Check Cleared \_\_\_\_/\_\_\_\_/\_\_\_\_  
{Attach copy of check if able to obtain from the TPL Carrier}

**Refund Information:**

Dollar Amount Due Provider to be refunded by State of TN Bureau of TennCare \$ \_\_\_\_\_

Brief Description of Situation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Where to Mail Refund:**

Mail to Attention of: \_\_\_\_\_

Mail to Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Provider Attestation:**

I hereby certify that the information provided above is correct and that Provider is due amount indicated.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*\*NOTE: COPY OF TENNCARE MCO RECOUPMENT EOB MUST BE ATTACHED TO THIS FORM\*\***

[Refund request may take up to 45 days to be completed]

TennCare Internal Use Only Below

Date Request Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Initials of Fiscal Agent: \_\_\_\_\_

Revision Date 5/11/2011