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