



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TN 37243

THIRD PARTY LIABILITY UPDATE FAX REQUEST

TO: TPL Coordinator

Fax Number: **(615) 734-5113**

Today's Date: _____

Number of Pages: _____

Provider Name: _____

Provider Address: _____

_____ TN _____

Provider Phone: _____

Contact Name: _____ Contact Number: _____

Recipient Name: _____ DOB (Date of Birth): _____

SSN: _____ Medicaid Recipient ID#: _____

Relationship to Policy Holder:

Self Spouse Dependent

Policy Holder:

Name: _____ SSN: _____

This Insurance Carrier Coverage Needs to be Terminated - TERM DATE: _____

OR

This Insurance Carrier Coverage Needs to be Added - EFFECTIVE DATE: _____

Insurance Carriers Name: _____

Policy Number: _____ Group Number: _____

Credible Coverage Letter Attached? Yes No

If this is a Medicare Policy, select the appropriate Medicare Policy type; otherwise select Not Applicable.

Advantage Plan Supplemental Plan Not Applicable

REMARKS:

(Limited to 500
Characters)

***All information requested on this form is required. Incomplete forms will not be processed.**