

TennCare Authorization of Representative Organization Form

After you fill out and sign this form, send pages 2 and 3 by mail or fax to:

TennCare Connect
P.O. Box 305240
Nashville, TN 37230-5240
Fax: 855-315-0669

Legal Basis

Based on the Title 42, Public Health regulations regarding Medicaid Eligibility (42 CFR 435.923), you have the right to designate an individual or an organization to act responsibly on your behalf. This includes matters regarding your TennCare eligibility, your application for TennCare coverage, and other ongoing matters with the Agency. This person or organization serves as an Authorized Representative in your interactions with TennCare.

Instructions for Submission

You must complete pages 2 and 3 of this form and return it to TennCare using the instructions on this page if you want an **ORGANIZATION** to represent you and act on your behalf in applying for medical benefits and/or act for you on an ongoing basis regarding medical coverage from the State of Tennessee, Division of TennCare. This includes programs such as TennCare Medicaid, CHOICES, or CoverKids. Both you and the organization you are selecting as your Representative must sign and date this form to accept the responsibilities of an Authorized Representative.

Other Categories of Representation

You do **NOT** need to complete this form to add an Authorized Representative if you have:

- **A Person Helping You:** This person only helps you understand the application or renewal form for TennCare coverage. You complete and sign the TennCare application or renewal form for yourself or your family.
- **A Legal Guardian:** This person acts on behalf of any minors or adults in their care. TennCare requires proof of guardianship.
- **Legal Representation under Tennessee law:** This includes Conservators or Powers of Attorney (POA). They can act on behalf of a TennCare member or applicant if a legal document, like a court order, gives them the right to do

Other Important Information

- If you only want specific medical information shared with an organization, you can complete the Permission to Release Member Information form instead of making them a Representative Organization.
- Choosing to have an Authorized Representative does **not** change your TennCare coverage or the way you get health care.
- You can also add, change, or end the responsibilities of an Authorized Representative through your **TennCare Connect** account at tenncareconnect.tn.gov. You can also call **TennCare Connect** at **855-259-0701**. If you are adding new responsibilities for your Representative Organization, they must agree.
- If you want to submit this form to TennCare in a way that is not listed on the form, please contact either TennCare Connect or the TennCare Privacy Office at Privacy.TennCare@tn.gov.
- Puede obtener estas hojas en español. Visite nuestro sitio web en www.tennessee.gov/tenncare. O bien, llame TennCare Connect al 855-259-0701.

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Applicant/Member Information

Name of Applicant/Member (Last, First, Middle Initial):

Phone Number:

ID Number (SSN or Member ID):

Date of Birth (MM/DD/YYYY):

Address:

City, State and Zip Code:

Email:

Responsibilities of Representative Organization

I understand and voluntarily agree that my Representative Organization is authorized to:

Please select any or all of the following options.

☐ (1) Sign an application on my behalf.

☐ (2) Complete and submit a renewal form for my TennCare coverage.

☐ (3) Receive copies of my letters and other communications from TennCare.

- This includes getting information from TennCare about the status of my application and eligibility, my general and financial circumstances, my insurance cards, and my medical conditions.

☐ (4) Act on my behalf on all other matters with TennCare.

- This includes coming to or speaking for me in any interviews or hearings, filing appeals on my behalf if my application is denied or my benefits are changed; and acting on my behalf for all other matters related to my eligibility determination.

Disclosure of Medical Information

- If I chose options (3) or (4) above, I voluntarily give permission and request disclosure of my medical information by TennCare to my Representative Organization and its employees in a manner consistent with my selections on this form.
- I understand that if I have selected options (3) or (4), this may include information about:
 - Medication I take now or have taken in the past;
 - My insurance card; and
 - Facts regarding my health and present or past alcohol or drug treatment;
 - It does not include psychotherapy notes that are not in my medical records.

Termination or Change of Authorization

You can call **TennCare Connect** at **855-259-0701** if you want to end or change the rights to your Authorized Representative. You can also do this by logging in to **TennCare Connect**, or by writing a letter to TennCare telling us that you want to end or change the rights of your Authorized Representative. This will not change facts we have already shared with your Representative Organization, but we won't share any more facts. Your Representative Organization must tell TennCare they agree if you want to add more responsibilities.

Puede obtener estas hojas en español. Visite nuestro sitio web en www.tennessee.gov/tenncare. O bien, llame **TennCare Connect** al **855-259-0701**.

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Signature of Representative Organization Employee

The Representative Organization understands that:

- The Representative Organization is expected to know about the applicant's/member's circumstances.
- The applicant/member can end the Representative Organization's responsibilities at any time.
- The Representative Organization must keep any information provided private. This includes but is not limited to health information and financial information of the applicant, pursuant to the regulations set forth in 42 CFR 435.923; 42 CFR 431 subpart f; 45 CFR 155.260(f), 42 CFR 447.10, as well as other state and federal laws.
- The Representative Organization must promptly give the applicant/member copies or originals of all relevant documents and information, such as letters or mail, that is sent from TennCare.
- The Representative Organization must tell the applicant/member and TennCare in writing if they no longer want to be the Authorized Representative.

Organization Name: Legal - Ease Digital Imaging

Address: 2496 Meadowcroft Dr

City, State and Zip Code: Burton, MI 48519

Organization Type (Eligibility Assistance Company, Institution): Records Retrieval company

Name of Organization Authorized Employee: Patricia Clifford

Title: Owner

Email: pat.legalease@gmail.com

Phone Number: 855-534-4003

Signature of Organization Authorized Employee:

Date:



Signature of Applicant/Member

I give this Representative my permission to act for me in the responsibilities listed above. I understand that:

- I am responsible for the information this Representative Organization gives.
- I may need to give more information and documents to my Representative Organization.
- I can change or end the responsibilities of my Representative at any time.
- My Representative can end their responsibilities at any time. They must tell TennCare about this change in writing.
- My Representative may get payment from my healthcare provider, such as a hospital where I received treatment, to assist with services on my behalf.
- My Representative cannot guarantee the outcome of any eligibility determination for my application.

I authorize this Representative to help me starting the date listed below for: (please check one)

If a timeframe is not selected for the duration of authorized representation, TennCare will assume 5 months.

☒ 3 Months ☐ 5 Months ☐ 1 Year ☐ Ongoing

If applicant/recipient is not able to sign, a legal representative may sign and provide legal documentation of authority (e.g. power of attorney, custody documentation)

Signature of Applicant/Member:

Signature of Legal Representative:

Date: