TennCare Authorization of Individual Representative

Section 1: Introduction

You must complete this form if you want **ANOTHER PERSON** to be your Representative 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, CoverKids and emergency medical services (EMS). Both you and your Representative must sign and date this form.

Section 2: Representative

Name of Individual:	Phone Number:
Street Address:	City, State and Zip Code:
Relationship with applicant/recipient (e.g. Family Member, Friend, Attorney):	

Section 3: Function of Representative

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

- Obtain from TennCare and submit to TennCare information about me with respect to my general and financial circumstances and medical condition;
- Complete, sign and submit an application and related documents on my behalf;
- Receive information regarding the status of my application and eligibility;
- Receive all notices or other communications regarding my application, appointments, redetermination or eligibility status;
- Accompany me or represent me for any required interview, hearing or appeal;
- Pursue the appeal process, up to and including legal proceedings, in the event my application is denied;
- Act on my behalf in all other matters related to my eligibility determination.

Section 4: Medical Information

- I voluntarily authorize and request disclosure by TennCare of all my medical information to my Representative for the purpose of assisting me with the eligibility determination process and other related functions listed above.
- I understand this may include information regarding medication I take now or have taken in the past and may include facts regarding my health and/or present or past alcohol or drug treatment. It does not include psychotherapy notes that are not in my medical records.
- I understand my eligibility and ability to obtain health care and coverage does not depend on my granting this authorization.
- I understand that information shared by my Representative may be shared with others. Not everyone has to follow privacy rules.
- My authorization for TennCare to release medical information to my Representative expires upon the termination of this authorization as described in Section 5 or designated in Section 7.

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

Section 5: Termination of Authorization

You can terminate this authorization at any time by calling TennCare Connect at 855-259-0701. Or by giving TennCare written notice that your Representative is no longer authorized to act on your behalf. This will not change facts we have already shared with your Representative, but we won't share any more health facts.

Section 6: Signature of Representative

In agreeing to be an authorized representative, I understand that I am expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time. I also agree to maintain the confidentiality of any information provided to me, including but not limited to health and financial information pursuant to all applicable state and federal rules and regulations.

Signature of Representative:	Date:

Section 7: Signature of Applicant/Recipient

I authorize this Representative to act for me regarding eligibility and related functions listed in Section 3. I understand that I am responsible for the information anyone acting as my authorized representative gives and I may be required to cooperate further, including providing information and documents. I also understand that I can terminate this authorization at any time by calling or giving TennCare written notice that my Representative is no longer authorized to act on my behalf.

I authorize this Representative to help me for: (please check one)
☐ 3 Months ☐ 5 Months ☐ 1 Year ☐ Ongoing; and starting the date listed below.

Name of Applicant/Recipient (Last, First, Middle Initial):	Phone Number:
ID Number (SSN):	Date of Birth (MM/DD/YYYY):
Address:	City, State and Zip Code:
Signature of Applicant/Recipient:	Date:

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

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