



**TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES**

REQUEST FOR INFORMATION

DEAR PATIENT:

ON _____ YOU RECEIVED SERVICES FROM THE _____ COUNTY HEALTH DEPARTMENT. WE BILLED TENNCARE FOR THE SERVICE, BUT THE CLAIM WAS DENIED BECAUSE THEIR RECORDS INDICATE YOU HAVE OTHER INSURANCE THAT MUST BE BILLED FIRST. SINCE WE DO NOT HAVE THE INFORMATION NECESSARY TO BILL YOUR PRIVATE INSURANCE COMPANY, WE REQUEST THAT YOU TAKE A FEW MOMENTS TO COMPLETE AND SIGN THE INSURANCE INFORMATION REQUEST AT THE BOTTOM OF THIS PAGE, SO WE CAN BILL FOR YOUR RECENT VISIT. PLEASE RETURN THIS INFORMATION TO THE ADDRESS LISTED BELOW. IF WE DO NOT RECEIVE THIS INFORMATION WITHIN 30 DAYS, YOU WILL BE HELD RESPONSIBLE FOR THE FULL AMOUNT OF YOUR VISIT.

IF YOU HAVE ANY QUESTIONS, YOU MAY CONTACT _____ AT () _____
_____ THANK YOU FOR YOUR ASSISTANCE IN RESOLVING THIS MATTER.

INSURANCE INFORMATION REQUEST

RETURN TO:

INSURANCE COMPANY: _____ **BILLING ADDRESS:** _____

EFFECTIVE DATE OF POLICY: _____ **POLICY NUMBER:** _____

NAME OF POLICY HOLDER: _____

I HEREBY AUTHORIZE THE _____ COUNTY HEALTH DEPARTMENT TO RELEASE MY MEDICAL RECORD AND/OR LAB RESULTS, IF REQUESTED BY THE ABOVE INSURANCE COMPANY, IN ORDER TO PROCESS MY CLAIM/CLAIMS. I ALSO AUTHORIZE THE PAYMENT TO BE PAID DIRECTLY TO THE _____ COUNTY HEALTH DEPARTMENT.

SIGNATURE OF PATIENT/PARENT/GUARDIAN: _____

DATE: _____