Emergency Medicaid

BEST PRACTICES GUIDE FOR TENNESSEE HOSPITALS

TENNESSEE JUSTICE CENTER
Introduction: The problem of applying for Emergency Medicaid

Emergency Medicaid is an important program created by Congress to help hospitals defray the cost of emergency care for undocumented immigrants, who typically lack insurance or the ability to pay for their own emergency medical care. Beginning in 2014, state policy and communication failures have created barriers to applying for the program, leaving many hospitals with large unpaid bills that Emergency Medicaid should have covered. This toolkit tells you how to use the appeal process to overcome the obstacles and get Emergency Medicaid coverage for your patients.

Since January 2014, Tennessee has required that almost all applications for Medicaid, or “TennCare,” be submitted to the federally facilitated marketplace (FFM), or online “insurance exchange.” The Tennessee Department of Human Services no longer accepts applications. The only exceptions to the state policy are applications for the long term services and supports program (known as CHOICES), for the Medicare Savings Programs, and Emergency Medical Services for nonqualified immigrants. These applications can be submitted via fax to Tennessee Health Connection, the communications center for TennCare.

Prior to the summer of 2015, the state required all applications, including Emergency Medicaid applicants, apply through the FFM. Because nonqualified immigrants often do not have Social Security numbers, they could not apply online or by phone. That left only the option of submitting paper applications to the FFM facility in London, KY. But coverage cannot take effect before the date of application, and a mailed application is not considered filed until it is actually received at the London facility. That meant a delay of at least one day, and the hospital’s loss of coverage for expenses incurred while the application was in the mail. To address delays caused by the mail, TennCare implemented a new policy in the summer of 2015 instructing hospitals to fax to Tennessee Health Connection (TNHC) a copy of the FFM application along with medical records at the time the FFM application is filed.

However, despite this new process, communication failures within the Health Care Finance and Administration have created problems for many applicants, including the delay and erroneous denial of applications. These delays and denials are especially problematic for hospitals seeking reimbursement for the emergency care of nonqualified immigrants.

Even after the application is submitted to the FFM by mail and faxed to TNHC, problems remain. It is common for the application to go for months without any action. As the application is being processed, a letter is often sent to the patient demanding information or documentation within ten days. If the information is not received within that time, the application is denied. The hospital is left with a large unpaid bill.

Federal law and a federal court order require TennCare to offer an appeal to anyone whose application for TennCare has been delayed beyond 45 days. (There is a 90 day deadline in some types of cases, but those are not relevant to Emergency Medicaid). This toolkit describes how to apply for Emergency Medicaid following TennCare’s guidelines, and how to use the appeal process to address delays and denials. It also explains how the appeal process can be used to move the effective date of coverage back to the original date on which the paper application was mailed to the FFM facility in London, KY and faxed to Tennessee Health Connection.
Important Take-Away

1) The law is on your side, and it IS possible to obtain Emergency Medicaid using the appeal process, BUT
2) To succeed, you must have a process that actively works and documents these cases in a manner that is beyond the capability of patients.
3) It is a hassle, but it is worth it to both the hospital and the patient.

Emergency Medicaid Defined

Federal law requires that state Medicaid programs cover emergency medical services for ineligible aliens, when these individuals otherwise meet the categorical and financial criteria for Medicaid. Approval of an Emergency Medicaid application only provides coverage for a single episode of care. (The same patient may qualify for Emergency Medicaid for separate episodes of care, provided that they are not for ongoing, routine care, as discussed below under the heading “The Sudden Onset Requirement.”) Furthermore, the coverage is limited to the length of time required to stabilize the emergent episode and only the services involved in the emergency itself will be reimbursed.

In essence, this is a four prong test to determine if the service qualifies for emergency Medicaid reimbursement:

1. The patient is an undocumented or ineligible alien; AND
2. The care meets the standard of “emergency care”; AND
3. The patient’s condition meets the “sudden onset” requirement; AND
4. The patient is otherwise categorically and financially eligible for Medicaid.

The patient must pass all four prongs of the test to qualify, including whether he or she is otherwise categorically and financially eligible to receive Medicaid. In other words, the patient’s immigration status is the sole reason he/she is ineligible for full Medicaid coverage.

This toolkit only addresses the first three prongs of the test. If you need assistance with Medicaid eligibility in general, please see the TJC Toolkit for TennCare and the Affordable Care Act. You can download it for free at www.tnjustice.org/help/trainings/toolkit/.

Definitions from the TennCare Medicaid and TennCare Standard Policy Manual

Federal regulations and the TennCare Medicaid and TennCare Standard Policy Manual use the terms “undocumented alien” and “undocumented immigrant,” while the TennCare Policy Manual titled Emergency Medical Services uses the terms “undocumented” and “ineligible aliens.” For the purposes of this toolkit, these terms can be used interchangeably.
| "Undocumented Alien" a/k/a "Undocumented Immigrant" or "Illegal Alien" | Undocumented A person who is NOT a citizen of the United States and who is not lawfully admitted for permanent residence (commonly referred to as LPR) or otherwise permanently residing in the United States under the color of law. This includes: 1) Undocumented aliens who were never legally admitted to the United States for any period of time; OR 2) Undocumented aliens who were legally admitted for a limited period of time and did not leave the United States when that period of time expired. |
| "Ineligible Alien" | Ineligible Alien is a person other than an undocumented alien who is not a citizen of the United States and whose alien status prevents him/her from qualifying for Medicaid. This includes: 1) Certain Qualified Aliens arriving on or after August 22, 1996 who may have been lawfully admitted to the United States, but who are prohibited from acquiring Medicaid during the first 5 years of residence in the United States. This is also referred to as “the 5 year bar”; OR 2) Aliens Admitted for a Temporary Purpose – aliens who are not permanently residing in the United States, but have been lawfully admitted to the country for a specified period of time. These aliens are not eligible for Emergency Medicaid during that specified period of time. |

**Exceptions to the 5 Year Bar**

Below is a list of certain classes of aliens that are exceptions to the 5 year bar. In other words, patients in any of these groups are eligible to apply for full Medicaid benefits provided they are otherwise categorically and financially eligible. **Because these classes of aliens are eligible for full Medicaid benefits as if they are US citizens, they are NOT eligible for Emergency Medicaid.**

<p>| Afghani Aliens Granted Special Immigration Status | Aliens admitted as Afghan Immigrants pursuant to section 525 of Title V described in Section 101(a)(27) of the Immigration and Nationality Act (INA). |
| Aliens Granted Conditional Entry | Aliens who are granted conditional entry pursuant to section 203(a)(7) of such Act [8 U.S.C. 1153 (a)(7)] as in effect prior to April 1, 1980 |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aliens Who Are Honorably Discharged Veterans or Active Duty Members of the US Armed Forces Plus Their Spouse &amp; Dependent Children</td>
<td>Veterans or active duty members of the U.S. Armed Forces, spouses of veterans, or dependent children of veterans/active duty members.</td>
</tr>
<tr>
<td>Aliens Who Are Members of a Federally-Recognized Indian Tribe</td>
<td>This group of aliens are not statutorily defined as &quot;qualified aliens,&quot; however, they are generally treated like qualified aliens for TennCare purposes.</td>
</tr>
<tr>
<td>Aliens Whose Deportation is Being Withheld</td>
<td>Aliens residing in the U.S. on an indefinite voluntary departure; or granted voluntary departure pursuant to §242(b) of INA; or granted suspension of deportation pursuant to §244 of INA; or aliens residing in the U.S. on an indefinite stay of deportation, or aliens whose deportation has been withheld pursuant to §243(h) of the INA.</td>
</tr>
<tr>
<td>Amerasian Immigrants</td>
<td>Aliens admitted to the U.S. as an Amerasian Immigrant pursuant to section 584 of the Foreign Operation, Export Financing, and Related Programs Appropriations Act of 1988.</td>
</tr>
<tr>
<td>American Indians Born in Canada</td>
<td>American Indians born in Canada under section 289 of the INA or members of a federally recognized Indian Tribe as defined in section 4 (e) of the Indian Self-Determination and Education Assistance Act.</td>
</tr>
<tr>
<td>Asylee</td>
<td>Alien granted asylum under section 208 of the INA. In general, Asylees are persons granted legal status due to persecution or a well-founded fear of persecution in their home countries. Asylees arrive in the US without authorization (or overstay a visa), claim asylum, and are granted asylee status once their application has been approved. Asylees can apply for permanent residency after 1 year.</td>
</tr>
<tr>
<td>Cuban or Haitian Entrants</td>
<td>Aliens granted Cuban and Haitian entrant status under section 501 (e) of the Refugee Assistance Act of 1980.</td>
</tr>
<tr>
<td>Iraqi Aliens Granted Special Immigration Status</td>
<td>Iraqi aliens who have been granted Special Immigrant status described in section 101(a)(27) of the Immigration and Nationality Act (INA) resettlement assistance entitlement programs,</td>
</tr>
<tr>
<td>Refugee</td>
<td>Aliens admitted as &quot;conditional entrants&quot; or refugees under 207 of the Refugee Act of 1980 (P.L. 96-212) or as refugees under §203 (a)(7) of the INA. In general, persons granted legal status due to persecution or a well-founded fear of persecution in their home countries. Refugee status is granted before entry into the US. Refugees can apply for permanent residency after 1 year.</td>
</tr>
<tr>
<td>Victims of a Severe Form of Trafficking</td>
<td>Adult victims of human trafficking who are certified by the U.S. Department of Health and Human Services (HHS).</td>
</tr>
</tbody>
</table>
Definition of “Emergency Services”

An “emergency medical condition” is the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any one of the following:

1. Placing the patient’s health in serious jeopardy;
2. Serious impairment of bodily functions; OR
3. Serious dysfunction of any bodily organ or part.

The “Sudden Onset” Requirement

The phrase “sudden onset” is a further qualifier that specifically excludes services for individuals who need ongoing routine care (e.g., dialysis, chemotherapy) for conditions that could become “emergency medical conditions” in the future.

- All labor and delivery service IS considered an emergency medical condition;
- Care and services related to an organ transplant procedure for aliens not lawfully admitted for permanent residence are NOT a covered emergency benefit.

Acceptable Medical Records Requirement

Submitting an application alone is not enough. Providers must also send documentation of the medical condition and treatment to TennCare, where the Bureau’s Medical Director will review the medical records submitted with the application to determine whether the services satisfy the definition of “emergency.” When submitting medical records, TennCare directs providers to use their approved EMS Cover Sheet (See Appendix 2) and write “EMS APPLICATION” on every page. According to TennCare, acceptable medical records include:

- Emergency department’s triage notes;
- Emergency department’s physician notes;
- Laboratory notes;
- Histories and physicals; AND/OR
- Hospital discharge summaries.

Medical records should be faxed with a copy of the FFM application to Tennessee Health Connections. Additional records may be sent after the original application has been faxed to establish length of stay, laboratory notes, billing, etc. (see Steps for Submitting Subsequent Documentation, below).

Steps for Applying for Emergency Medicaid

Below you will find the steps to apply for Emergency Medicaid that will increase the likelihood of a patient’s treatment being covered by Emergency Medicaid. These steps are a combination of the procedural steps outlined in the TennCare Policy Manual (including subsequent updates) and The Delay Application Appeals Desk Guide dated 4/27/2015, as well as our experiences navigating the application and eligibility determination process of the FFM and the TennCare Bureau.
It is recommended that you maintain a log of all pending Emergency Medicaid applications, appeals and dispositions for your entity or organization.


| Step 2 | Send one copy by express delivery, Certified Mail Return Receipt requested, to: |
|        | **Health Insurance Marketplace** |
|        | 465 Industrial Blvd. |
|        | London, KY 40750-0061 |

| Step 3 | Complete TennCare’s Tennessee Health Care Finance and Administration Authorization of Representative Organization form (Appendix 1), and have the patient sign it. This form lets the provider act on behalf of the patient when applying for medical benefits. Since Emergency Medicaid is limited to a single episode of care, it is in the provider’s interest to act on behalf of the patient. |

| Step 4 | Using TennCare’s Emergency Medical Services Cover Sheet (Appendix 2), fax a copy of the FFM paper application (including proof of mailing from step 2) and the medical records to document the existence of an emergency pursuant to the definitions above to Tennessee Health Connection at **1-855-315-0669**. Write the words, “EMS APPLICATION” on the top of every page submitted to Tennessee Health Connection (TNHC). With the exception of labor and delivery, note the very specific nature of the emergency, and that it could not have been foreseen. Failure to do so (as well as advance requests for coverage) will result in the application being denied for failure to meet the "sudden onset" requirement. Proof of income should also be provided, if available. **Fax the application on the date of admission if possible, even if medical records are not yet available.** |

| Step 5 | Place copies of the application and proof of fax (including the date and time this was done) and mailing in the patient’s record. |

<p>| Step 6 | If proof of income was not submitted with the application to TNHC, provide the applicant with the TJC TennCare Income Verification Handout (Appendix 3). Have the patient provide copies of paystubs (if any) or proof of other income from all household members for the last 8 weeks. Chances are the patient will be required to provide this information within 10 days. Once received from the patient, fax copies to TNHC as outlined in the Steps for Submitting Subsequent Documentation section (see below). You should not wait for an official request from TennCare before faxing to TNHC. |</p>
<table>
<thead>
<tr>
<th>Step 7</th>
<th>Calculate and record the date 45 calendar days from the application date in the patient’s file. This is the <strong>application deadline date</strong>, the deadline imposed by federal regulations within which the state must decide whether to approve the application.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 8</td>
<td>Have the patient sign TennCare’s Medical Release Form (Appendix 4). Add the form to the patient file. You may need this form in the future.</td>
</tr>
<tr>
<td>Step 9</td>
<td>Follow-up with the patient on the date (in step 4) that marks the end of the 45 day time period for an eligibility determination. Also, inform the patient to notify you of any requests for information, denials etc. and record in the patient’s file.</td>
</tr>
</tbody>
</table>
| Step 10 | If after 45 days a decision has not been rendered on the application, complete the TennCare Eligibility Appeal form (Appendix 5). Check the box indicating the application is delayed in Section 5 and note the application date in Section 7. Attach the following:     
  a. EMS Application Cover Sheet     
  b. Application and proof of the application date (fax and certified mail receipts);     
  c. Medical Records establishing the sudden onset of an emergency medical condition;     
  d. Medical bills associated with the medical services. |
| Step 11 | Fax the Appeal to TNHC at **1-855-315-0669**. Place copies of the fax receipt in the patient file. Obtain a proof mailing or the fax receipt as proof and record in the patient’s file. |
| Step 12 | Record patient information in the log/report of pending Emergency Medicaid appeals and dispositions for your entity or organization. |
| Step 13 | If the application is denied, or if it is approved but with a coverage date later than the date on which the application was mailed to the FFM in London, KY, file an appeal with TennCare through TNHC by completing and faxing the TennCare Eligibility Appeal form (Appendix 5) to **1-855-315-0669**. Submit proof that the application was filed on an earlier date. Submit documentation of the patient’s household composition and income, as well as proof of the emergency nature of the medical care. Also send the TennCare release (Appendix 4) and Authorization of Representative Organization (Appendix 1) to TNHC and ask for the hospital to be copied on any communications related to the appeal. |
| Step 14 | Try to contact the patient and ask him/her to respond promptly to any requests for information regarding the appeal, and to notify hospital staff whenever he/she receives a communication from TennCare or the FFM. |
| Step 15 | In some instances, TennCare rejects eligibility appeals for failure to raise a valid factual dispute. In these cases, the appellant receives a notice (see Appendix 6) dismissing his/her request for a hearing because “you did not tell us about a mistake that, if you’re right, means you are eligible for TennCare.” The notice allows 10 days for the appellant to submit additional information to TennCare in writing. If a patient receives this notice, please contact the Tennessee Justice Center for assistance at **(615) 255-0331**. |
Steps for Submitting Subsequent Documentation

After the original application has been mailed to the FFM and faxed to TNHC, chances are additional documentation will be created that supports the application. This could be additional physician notes, laboratory notes, billing, income verification, etc. Follow the steps below in order to increase the chances of complete reimbursement for medical services.

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Use TennCare’s Emergency Medical Services (EMS) Cover Sheet for Application/Verifications (Appendix 2) when faxing information to TNHC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2</td>
<td>Write “EMS APPLICATION” at the top of every page faxed to TNHC.</td>
</tr>
<tr>
<td>Step 3</td>
<td>Whenever faxing additional information to TNHC, include the original FFM application, proof of mailing to the FFM AND original fax confirmation page along with any other documents that were previously faxed to THC.*</td>
</tr>
</tbody>
</table>

*NOTE:* We recommend faxing ALL documents related to the request for EMS Medical Services in the event prior documentation relating to the patient cannot be found by TennCare. In other words, TennCare should be able to render a decision based solely on the last set of documents that were faxed. Please do not assume TennCare will be able to locate and consider previously submitted documentation and/or applications.

Helpful Resource Contact Information

<table>
<thead>
<tr>
<th>Area Agencies on Aging and Disabilities (AAAD)</th>
<th>1-866-836-6678</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriGroup</td>
<td>1-800-600-4441</td>
</tr>
<tr>
<td>BlueCare</td>
<td>1-800-468-9698</td>
</tr>
<tr>
<td>Blue Cross Blue Shield TN</td>
<td>1-877-942-2144</td>
</tr>
<tr>
<td>Cigna</td>
<td>1-800-997-1654</td>
</tr>
<tr>
<td>Community Health Alliance</td>
<td>1-888-415-3332</td>
</tr>
<tr>
<td>CoverKids</td>
<td>1-866-620-8864</td>
</tr>
<tr>
<td>CoverRx</td>
<td>1-866-268-3779</td>
</tr>
<tr>
<td>Family Assistance Service Center</td>
<td>1-866-311-4287 or 615-743-2000</td>
</tr>
<tr>
<td>Get Covered Hotline</td>
<td>1-844-644-5443</td>
</tr>
<tr>
<td>Health Assist</td>
<td>1-800-269-4038</td>
</tr>
<tr>
<td>Humana</td>
<td>1-615-221-2155</td>
</tr>
<tr>
<td>Marketplace Hotline</td>
<td>1-800-318-2596</td>
</tr>
</tbody>
</table>
Medicare 1-800-633-4227
Mental Health Crisis Line (Statewide) 1-800-809-9957
SHIP (State Health Insurance Assistance Program) 1-877-801-0044 or 1-866-836-7677
Social Security Administration 1-800-772-1213
TennCare Bureau 1-800-342-3145 or 615-507-6000
TennCare Advocacy Program 1-800-758-1638
TennCare Fraud and Abuse Line (TennCarefraud@state.tn.us) 1-800-433-3982 Fax: 615 256 3852
TennCare Long-Term Care and Services 1-877-224-0219
TennCare Select 1-800-263-5479
TennCare Solutions Unit (TSU) 1-800-878-3192
TennCare Spanish-speaking Information Line 1-800-254-7568
TennCare TTY for persons with speech and hearing impairments 1-800-779-3101 or 615-313-9240
Tennessee Health Connection Hotline 1-855-259-0701
Tennessee Justice Center 1-877-608-1009 or 615-255-0331
United HealthCare Community Plan 1-800-414-9025

Mailing Addresses & Fax Numbers
HCFA (Eligibility Delay Appeals) Tennessee Health Connections
PO Box 23650 PO Box 305240
Nashville, TN 37202 Nashville, TN 37202

Health Insurance Marketplace
465 Industrial Blvd
London, KY 40750-0061

Still Have Questions?
Contact the Tennessee Justice Center at 615.255.0331. We will provide you with some additional information and strategies to try, but due to exceptionally high case volume we may be unable to accept individual cases at this time.

Appendix
Appendix 1 – TennCare Form: Tennessee Health Care Finance and Administration Authorization of Representative Organization
Appendix 2 – TennCare Form: Emergency Medical Services (EMS) Cover Sheet for Application/Verifications
Appendix 3 – TJC TennCare Income Verification Handout
Appendix 4 – TennCare Form: Medical Release Form
Appendix 5 – TennCare Form: TennCare Eligibility Appeal Form
Appendix 6 – TennCare HCFCA Notice: Appeal dismissed for no valid factual dispute

TennCare
615.255.0331
615.255.0354 fax
Tennessee Health Care Finance and Administration
Authorization of Representative Organization

You must complete this form 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, Health Care Finance and Administration (HCFA). This includes programs such as TennCare Medicaid, CHOICES, CoverKids and emergency medical services (EMS). Both you and a member of the organization must sign and date this form.

**Applicant/Recipient**

<table>
<thead>
<tr>
<th>Name of Applicant/Recipient (Last, First, Middle Initial):</th>
<th>Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID Number (SSN):</td>
<td>Date of Birth (MM/DD/YYYY):</td>
</tr>
<tr>
<td>Address:</td>
<td>City, State and Zip Code:</td>
</tr>
</tbody>
</table>

**Scope of Authorization**

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

- Obtain from HCFA and submit to HCFA 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.

**Medical Information**

- I voluntarily authorize and request disclosure by HCFA of all my medical information to my Representative Organization and its employees 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 psycho-therapy 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 HCFA to release medical information to my Representative Organization expires upon the written termination of this Authorization.


HCFA ARO 7/2014
Termination of Authorization
You can terminate this authorization at any time by giving HCFA written notice that your Representative Organization is no longer authorized to act on your behalf. This will not change facts we have already shared with your Representative Organization, but we won’t share any more facts.

Signature of Representative Organization Employee
The authorized Representative Organization understands it is 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. The Representative Organization agrees to protect and maintain the confidentiality of any information provided to it, including individually identifiable 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 relevant state and federal laws. The Representative Organization also agrees to promptly provide to the Applicant/Recipient copies or originals of all relevant documents, communications and mailing enclosures received from HCFA related to the purposes specified in this authorization.

<table>
<thead>
<tr>
<th>Organization Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Organization Type (Eligibility Assistance Company, Institution):</td>
</tr>
<tr>
<td>Name of Organization Authorized Employee:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
<tr>
<td>Signature of Organization Authorized Employee:</td>
</tr>
</tbody>
</table>

Signature of Applicant/Recipient
I authorize this Representative Organization to act for me regarding eligibility and related functions listed above. 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 understand that I can terminate this authorization at any time by giving HCFA written notice that my Representative Organization is no longer authorized to act on my behalf. I also understand that my Representative Organization can withdraw as my representative at any time by notifying HCFA in writing and shall also notify me in writing of such withdrawal.

I understand that the Organization may receive payment from my healthcare provider, such as a hospital where I received treatment, to provide these assistance services on my behalf. I understand that the outcome of any eligibility determination regarding my application cannot be guaranteed by the Representative Organization.

| 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).

Emergency Medical Services (EMS)
Cover Sheet for Application/Verifications

Instructions:
1. Use this cover sheet any time you send information or documents about any EMS case.
2. Mark each page with "EMS APPLICATION" at the top.
3. Attach the original application form and original fax confirmation if you can.
4. Mail or fax this page and other documents to:

   Tennessee Health Connection (TNHC)
P.O. Box 305240
Nashville, TN 37230-5240
Fax: 1-855-315-0669

<table>
<thead>
<tr>
<th>Patient's Full Name (First, Middle, Last):</th>
<th>Patient's Telephone #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address:</td>
<td></td>
</tr>
<tr>
<td>Apt:</td>
<td>City, State and ZIP:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>SSN (if patient has one):</td>
</tr>
<tr>
<td>Date of Emergency Room Visit/Hospital Admission:</td>
<td>Date of EMS Application to TNHC:</td>
</tr>
</tbody>
</table>

Background Information: As required by federal law, TennCare reimburses hospitals for emergency medical services (EMS) for certain non-citizens. These noncitizens include qualified aliens subject to the 5-year bar and non-qualified aliens who are not eligible for regular TennCare because of their immigration status. TennCare reimburses hospitals for EMS only if the noncitizen:

- Would be eligible for an existing TennCare eligibility group but for his/her immigration status; and
- Has an EMS period on the date on which he or she received emergency services; and
- Got emergency services that meet the federal standards.

EMS applicants should submit the FFM application form to both TNHC and the FFM. EMS applicants should also send income, residency, and emergency medical documentation to TNHC as soon as it is available.

TennCare will not provide reimbursement for EMS if an applicant is a citizen or eligible immigrant. Citizens and eligible immigrants can instead apply for regular TennCare. For more information about eligibility for EMS and about regular TennCare, visit tn.gov/tenncare.

Attachments: Original EMS Application (if available)
Fax confirmation TNHC received original EMS Application (if available)
You applied for TennCare, Medicare Savings Programs or CHOICES.

TennCare might ask you for proof of your income for the month you applied and the month before. Please give the hospital proof of your income for the past 8 weeks. The hospital will save this information for you in case TennCare asks for it later.

Here are some types of income and what can count as proof:

<table>
<thead>
<tr>
<th>Type of income</th>
<th>Proof</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income for a job</td>
<td>Paystubs from the past 8 weeks; OR a letter from your employer showing how much you make</td>
</tr>
<tr>
<td>Self-employment income</td>
<td>Copies of your latest tax returns or bank statements from your business</td>
</tr>
<tr>
<td>Social Security payments</td>
<td>Letters from Social Security that show your check amount</td>
</tr>
<tr>
<td>Unemployment</td>
<td>Letters or statements from the unemployment office</td>
</tr>
<tr>
<td>Other income</td>
<td>Papers or bank statements that show any other income you received over the past 8 weeks</td>
</tr>
</tbody>
</table>

You don’t need to show proof of income from SSI or child support.

If you have no income, look for a copy of your last termination notice from your job, if you have it.

You should receive a decision on your application by ____________________. If you don’t receive a decision by that date, call your doctor’s office/hospital.
1. Who is the patient?

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID Number (SSN)</th>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Phone Number (with area code)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address | City | State | Zip Code
---------|------|-------|--------

Check One:
☐ I am the patient  OR
☐ I have the legal right to act for this person. (Check one below; if "other" fill in blank)
   I am his or her: ☐ Parent   OR  ☐ Guardian   OR  ☐ Other __________

Only TennCare or your TennCare providers can give out your health facts.

2. Who can my health facts be given to?

<table>
<thead>
<tr>
<th>Name (like family members who live with me, or a place of business)</th>
<th>Phone Number (with area code)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address | City, State, and Zip Code
---------|-------------------------

3. What health facts can we share?

We'll only share the health facts you OK. Tell us the health facts from your records you say can be shared. Give the date or place if you can.

<table>
<thead>
<tr>
<th>Health Facts</th>
<th>Date I got the care</th>
<th>Name of the place I got care from</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you give us your OK to share this kind of health information, tell us by checking the box.
☐ HIV/AIDS     ☐ Alcohol/Substance Abuse Records   ☐ Sexual/Physical/Mental Abuse
☐ Mental Health Records   ☐ Other

This OK includes medicine you take now or have taken for the health facts you say we can share. AND, it includes facts in your record about your health and/or your alcohol and drug treatment. It doesn't include psycho-therapy notes that aren't in your medical records.

4. Why are you giving out this health information?

Is it to get health treatment, or for court or work? Or are you asking for these records to be sent directly to you for you to use?
5. When does my OK end?
Your OK ends when you tell us it does. But, this OK can’t be for more than 1 year. Tell us when.
☐ My OK ends on this date __________ OR
☐ My OK ends when this happens:
(It can be something like “you can share my medical records this one time.”)
What if you don’t tell us when you want your OK to end? Then we will end your OK one year from when you sign. After one year, we will need a new OK.

6. Your Rights and Important Information
- Giving your OK is up to you. You don’t have to share your health facts.
- You don’t have to OK this paper. You will still get benefits and treatment.
- You can take back your OK. You must tell us in writing.
  Mail it to TennCare Privacy Officer, 310 Great Circle Road, Nashville, TN 37243.
- What if you take back your OK? It won’t take back the health facts we have already shared. But, we won’t share any more of your health facts.
- If we share your health facts with the people or agencies you named, they may share it with others. Not everyone has to follow privacy rules.

You have a right to get a copy of this signed OK. If you need another copy, call the TennCare Privacy Office at 1-866-797-9469. We can charge for copies of records as allowed by law.

Do you have questions or need help with this paper? Call the Tennessee Health Connection for free at 1-855-259-0701. They can help you Monday to Saturday from 7am to 7pm.

7. Signature of Patient
I give my OK to share the information listed in this paper. This paper can be an original or a copy.

Sign Here:_______________
Signature or Mark (“X”) of Patient __________________________
Date __________________________
( )
If signed “X” please tell us the person’s name who helped you.

Helper’s Address, City, State, Zip Code

8. Signature of Authorized Representative (if you have one)
Authorized Representative means you have legal proof you can act for this person. You must give us a copy of this proof. A representative signs for a patient who may not legally sign on his or her own.
If the patient is less than 18 years old, a parent or guardian should sign for the minor.

Signature of Person signing on behalf of patient __________________________
Date __________________________
( )
Printed Name __________________________
Phone __________________________

Address, City, State, Zip Code

NOTICE TO ANY RECIPIENT OTHER THAN THE PATIENT
This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.
The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
Having problems getting TennCare, CHOICES, or QMB/SLMB?

Use these pages only to file a TennCare Eligibility Appeal.

Fill out both pages. These are facts we must have to work your appeal. If you don’t tell us all the facts we need, we may not be able to decide your appeal. You may not get a fair hearing. Need help understanding what facts we need? Call us for free at 1-855-259-0701. If you call, we can also take your appeal by phone.

1. Who is the person that wants to appeal?

Full name ___________________________ Date of birth __ / __ / ___
Social Security Number ______-_____-_____
Current mailing address ______________________________
City ____________________ State _______ Zip Code __________

What language do you speak best?

☐ English ☐ Spanish ☐ Kurdish ☐ Somali ☐ Arabic ☐ Vietnamese ☐ Bosnian ☐ Other __________

If Spanish, do you need us to send your letters in Spanish? ☐ Yes ☐ No

2. Are there other people in your household who have this same problem?

Give us their names, dates of birth, and social security numbers.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

3. Who filled out this form?

If not the person that wants to appeal, give us your contact information:

Name ______________________________
Address _____________________________________________
Phone ___________________ Fax ____________________

Are you a: ☐ a parent or relative ☐ an advocate or friend ☐ an attorney ☐ a health care provider
☐ Guardian or Conservator ☐ Other ________________

For us to speak to this person about the appeal, we may need an OK in writing. To give us an OK in writing, you can use our HIPAA Permission to Release Records.

Go to http://www.tn.gov/tenncare/forms/releaserecord.pdf to print it and send it to us with these pages.

Keep reading. There is 1 more page for you to fill out.

Rev: 02Oct14
4. **What kind of coverage is the appeal for?**
   - [ ] TennCare
   - [ ] CoverKids
   - [ ] CHOICES
   - [ ] QMB or SLMB

5. **What is the problem you are having?**
   - [ ] My application has not been processed in 45 days (90 days for CHOICES).
   - [ ] My start date for my coverage is wrong.
   - [ ] I was denied coverage.
   - [ ] My Patient Liability amount is wrong.
   - [ ] My coverage ended or is ending.
   - [ ] Other  Please explain: ___________________________

6. **Have you or anyone in your household appealed this problem before?**
   - [ ] Yes  [ ] No

7. **Tell us why you want to appeal this problem.** Include any mistake you think TennCare made. And, send copies of any papers that you think may help us understand your problem.

8. **Has your coverage ended? Is your coverage ending?**

   You may be able to keep your coverage during your appeal. **If you keep your coverage during your appeal and you lose, you may have to pay TennCare back.**

   - [ ] Check this box if you want to ask to keep your coverage during this appeal. You will get a letter from TennCare that tells you if you can keep your coverage during your appeal.

   **How to file your eligibility appeal**

   Then, **mail** these pages and other facts to:

   Tennessee Health Connection  
P.O. Box 305240  
Nashville, TN 37230-5240

   Or, **fax** it (toll-free) to 1-855-315-0669. **Keep a copy** of the page that shows your fax went through.

   To appeal by **phone**, call 1-855-259-0701 for free.

   Have speech or hearing problems? If you have a hearing or speech problem you can call our Tennessee Relay Service (TNRS) at 1-800-848-0298. Then ask for the Tennessee Health Connection at 1-855-259-0701 and choose option 4.

   **We do not allow unfair treatment in TennCare.** No one is treated in a different way because of race, color, birthplace, religion, language, sex, age, or disability. Do you think you’ve been treated unfairly? Do you have more questions or need more help? If you think you’ve been treated unfairly, call the Tennessee Health Connection for free at 1-855-259-0701.

Rev: 02Oct14
Case ID: [redacted] (This is the number we use to track your appeal.)

Nov 12, 2015

Dear [redacted],

When you file an appeal, you're asking to tell a judge about the mistake you think TennCare made. It's called a fair hearing. To get a fair hearing, all 3 of these things must be true:

1. You must give us the facts we need to work your appeal.
2. AND, you must tell us the mistake you think we made.
3. AND, that mistake must be something that, if you're right, means you qualify for Medicaid.

But, you did not tell us about a mistake that, if you're right, means you qualify for Medicaid. So, you can't have a fair hearing.

Do you disagree? Tell us why you disagree or give us more facts. You have 10 days from the date of this letter to do so. You must tell us in writing why you disagree or give us more facts.

There are 3 ways to send it to us.

By mail: Eligibility Appeals
PO Box 305240
Nashville, TN 37230-5240

By Fax: 1-844-563-1728

Rev: 08Oct15
By Email: appeals.clerk.tenncare@tn.gov
Do you have questions about this letter? Call us at 1-844-202-5618. It’s a free call.

You can’t have a fair hearing just because you don’t agree with our rules. To get a fair hearing, you must tell us in writing the mistake you think TennCare made. If we don’t get more facts from you within 10 days, your appeal will be dismissed (closed).
[ Tenn. Comp. R. & Regs. 1200-13-19-05(3)]

Do you need help with this letter? Is it because you have a health problem, learning problem or a disability? Or, do you need help in another language? If so, you have a right to get help, and we can help you. Call the Tennessee Health Connection at 1-855-259-0701.

- Do you have a mental illness and need help with this letter?
The TennCare Advocacy Program can help you.
Call them for free at 1-800-758-1638.

- If you have a hearing or speech problem you can call our Tennessee Relay Service (TNRS) at 1-800-848-0298. Then ask for the Tennessee Health Connection at 1-855-259-0701 and choose option 4.

¿Habla español y necesita ayuda con esta carta? Llámenos gratis al 1-855-259-0701.

We do not allow unfair treatment in our program. No one is treated in a different way because of race, color, birthplace, religion, language, sex, age, or disability. Do you think you’ve been treated unfairly? Do you have more questions or need more help? If you think you’ve been treated unfairly, call the Tennessee Health Connection for free at 1-855-259-0701.