

Immediate Eligibility Notification Form

Is the child currently in DCS Custody? Yes { } No { }

Is the child currently in a Youth Development Center (YDC)? Yes { } No { }

Date of DCS Custody: ____ - ____ - ____

EPSDT Screening Appointment Date: _____

DCS Health Advocate Rep Name: _____

DCS Health Advocate Rep Telephone Number: _____

DCS Health Advocate Rep Address: _____

Street

City

ST

Zip

Member's Social Security Number: _____

Member Name: _____

Last Name

First Name

MI

Date of Birth: ____ - ____ - ____

Sex: Female _____ Male _____

Race: _____

County of Commitment _____ County of Placement _____

1st Choice: Best Practice Network PCP: _____ Provider Number: _____

2nd Choice: Best Practice Network PCP: _____ Provider Number: _____

Other Insurance (besides TennCare): Yes { } No { }

Name of Insurance Carrier: _____ Effective Date: _____

Name of Policy Holder: _____ ID Number: _____

I wish to apply for *TennCareSelect* based on eligibility requirements. I certify that the information on this form is true and correct to the best of my knowledge. *I understand that the eligibility must still be processed through the Child Benefit Worker. The Bureau of TennCare determines the eligibility.*

Signature of DCS Representative **Title** (person completing form) **Date** **Region**

Telephone Number: _____ **Fax Number:** _____

Fax to: *TennCareSelect SelectKids* Unit Fax Number: 1-800-330-2842 Phone Number: 1-800-451-9147

To be Completed by TennCareSelect

TennCareSelect Eligibility Date: _____ By: _____

Member Assigned to *TennCareSelect* Provider: _____

Comments: _____

Referral Needs:

- Medical
- Behavioral
- Disease Mgmt.
- Case Mgmt.