BlueCare Tennessee

TennCare Coverage Restrictions (Public Chapter 765) Attestation Form

Find this form online in the **Documents and Forms** section of **bluecare.bcbst.com/providers**.

Note: If the following information isn't complete, correct or legible, it may delay the prior authorization process. Please use one form per member.

Member Information (Required)

Member Name: _____

Member ID Card Number: _____ Date of Birth: _____ /_____ /_____

Streeet Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Provider Information (Required)

Provider Name: _____

NPI#: _____ DEA#: _____

Specialty: _____

Office Phone: _____ Office Fax: _____

Office Street: _____ State: _____ ZIP: _____

Is the prescriber a TennCare provider with a Medicaid ID? ☐ Yes ☐ No

Requested Service

Service: _____ Type and Amount Ordered: _____

By signing, the prescribing Physician confirms the above information is accurate and is verifiable by patient records and that this medication is being prescribed in compliance with Tennessee law, Tenn. Comp. R. & Regs. 1200-13-13-.10(1)(f); Tenn. Comp. R. & Regs. 1200-13-13-10(1)(m); TN Legis 765 (2026), 2026 Tennessee Laws Pub. Ch. 765 (H.B. 2498), effective July 1, 2026. All continuation of therapy prior authorizations will be approved through March 31, 2027.

Presciber Signature (Required): _____ **Date:** _____/_____/20 _____

(By signing, the physician confirms the above information is accurate and verifiable by patient records.)

Please attach relevant clinical information to this form.
Fax the completed form and clinical information to **800-292-5311**.

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