UnitedHealthcare Community Plan

Tennessee Health Link Provider Attestation Form

Please use this form when attesting new member attribution or requesting a care provider change for an existing Tennessee Health Link member. The effective date of the provider change for the Tennessee Health Link member will be the first day of the month following the request. If you have questions, please contact Provider Services at 800-690-1606. Thank you.

Section 1: Member Information
Member Name:
Date of Birth:
Legal Guardians Name (If younger than age 18):
UnitedHealthcare Community Plan ID Card # or Medicaid #:
Phone Number:
Section 2: Attesting Tennessee Health Link Care Provider Information
Name:
Care Provider ID#:
Phone Number:
Fax Number:
Name of Requester:
Section 3: Reason for Attestation
☐New Attribution ☐Care Provider Change ☐Member Opt Out
Section 4: Attestation Details for Category 3 (not required for provider change)
Please note: Attestation details are only needed for newly attributed members based on Category 3. Attestation details are not required for a care provider change. ICD-10 Diagnosis Code: _____ Functional Need: ☐ This member has functional needs that meet the Tennessee Health Link criteria for Category 3. Service Date: _____ (Date of service when the Tennessee Health Link care provider provided the service to the member.)
Please fax the completed form to UnitedHealthcare Community Plan at 888-785-1434.