



DISCRIMINATION COMPLAINT

Federal and state laws do not allow the Cover Tennessee Programs to treat you differently because of your race, color, birthplace, disability, age, sex, and religion. Do you think you have been treated differently because of your **race, color, birthplace, disability, age, sex, or religion**? Use these pages to report a complaint to your Cover Tennessee Program.

The information marked with a star (*) must be on the complaint. If you need more room to tell us what happened, use other sheets of paper and mail them with your complaint.

1.* Write your name and address.

Name: _____

Address: _____

_____ Zip: _____

Telephone: Home: (____)_____ Work or Cell: (____)_____

Email Address: _____

2.* Are you reporting this complaint for someone else? Yes No

If Yes, who do you think was treated differently because of their **race, color, birthplace, disability, age, sex, or religion**?

Name: _____

Address: _____

_____ Zip: _____

Telephone: Home: (____)_____ Work or Cell: (____)_____

How are you related to this person(s) (wife, brother, friend, etc...)? _____

3.* The Cover Tennessee Program that you think treated you in a different way:

- CoverTN
- CoverRx
- AccessTN
- CoverKids
- HealthyTNBabies

4.* How do you think you were treated in a different way? Was it your –

- Race
- Birthplace
- Color
- Sex
- Age
- Disability
- Religion

Other (specify): _____

5. What is the best time to talk to you about this complaint? _____

6.* When did this happen to you? Do you know the date?

Date it started: _____ / _____ / _____ Date of the last time it happened: _____ / _____ / _____

7. Complaints must be reported by 180 days (6 months) from the date you think you were treated in a different way. You may have more than 180 days to report your complaint if there is a good reason (like a death in your family or an illness) why you waited.

8.* Tell us what happened, how it happened and why you think it happened. Who did it? Was anyone else treated in a different way? You can write on more paper and send it in with these pages if you need more room.

9. Did anyone see you being treated differently? If so, please tell us their:

Name	Address	Telephone
		()
		()
		()

10. Do you have any other information you want to tell us about?

11.* We cannot take a complaint that is not signed. Please write your name and the date on the line below. Are you the Personal Representative of the person who thinks they were treated differently? Please sign your name below. As Personal Representative, you must attach a copy of the legal document giving you the right to act on behalf of this person.

Declaration: *I agree that the information in this complaint is true and correct and for Cover Tennessee to investigate my complaint.*

_____/_____/_____
(Sign your name here if you are the person this complaint is for) (Date)

_____/_____/_____
(Sign here if you are the Personal Representative) (Date)

Are you reporting this complaint for someone else but you are **not** the person's Personal Representative? Please sign your name below. The person you are reporting this complaint for must **also** sign the line above **or** must tell BCBST or Express Scripts Inc. or his/her Cover Tennessee Program that it is okay for them to sign for him/her. **Declaration:** *I agree that the information in this complaint is true and correct and for Cover Tennessee to investigate my complaint.*

(Sign here if you reporting this for someone else) _____ / _____ / _____
(Date)

It is okay to report a complaint to BCBST, Express Scripts Inc., CoverTN, AccessTN, CoverKids, CoverRx or HealthyTNBabies. Information in this complaint is treated privately. Names or other information about people used in this complaint are shared only when needed. Please mail a signed Agreement to Release Information with your complaint. If you are filing this complaint on behalf of someone else, have that person sign an Agreement to Release Information and mail it with this complaint. Please mail the completed, signed Complaint Form **and** the signed Agreement to

Release Information to:

Office of Non-Discrimination Compliance, Cover Tennessee Programs
Division of Health Care Finance and Administration
310 Great Circle Road, 4th Floor
Nashville, TN 37243

Be sure to make a copy of everything you send in and keep the copies for your records.

Do you need language help? Call 1-800-874-8426 or for TDD/TTY help call 1-800-899-2114.
Need Member Services help? Call 1-888-560-2649. Federal and state laws protect your rights.

No one is treated in a different way because of race, color, birthplace, religion, language,
sex, age or disability/handicap.

Need help? Call the Office of Non-Discrimination Compliance for free at 1-855-286-9085 or
For TTY/TDD dial 711 and ask for 855-286-9085.



Agreement to Release Information

To investigate your complaint, your Cover Tennessee Program and Express Scripts Inc., may need to tell other persons or agencies important to this complaint your name or other information about you.

To speed up the investigation of your complaint, read, sign, and mail one copy of this Agreement to Release Information with your complaint. Please keep one copy for yourself.

- I understand that during the investigation of my complaint the Cover Tennessee Program and Express Scripts, Inc. may need to tell people my name or other information about me to other persons or agencies. For example, if I report that my pharmacy treated me in a different way because of my age, CoverRx may need to talk to my pharmacy.
- You do not have to agree to release your name or other information. It is not always needed to investigate your complaint. But, if you don't agree to let us use your name or other details, it may stop the investigation of your complaint. And, we may have to close your case.

If you are filing this complaint for someone else, we need that person to sign the Agreement to Release Information. Are you signing this as a Personal Representative? Then you must also give us a copy of the legal documents appointing you as the Personal Representative.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to Cover Tennessee Program CoverRx, telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to Express Scripts Inc. telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

This Agreement to Release Information is in place until the final outcome of your complaint. You may cancel your agreement at any time by calling or writing to your Cover Tennessee Program or to Express Scripts Inc. without canceling your complaint. If you cancel your agreement, information already shared cannot be made unknown.

Signature: _____ Date: _____ / _____ / _____

Name: _____

Address: _____

_____ Zip: _____

Telephone: Home: (_____) _____ Work or Cell: (_____) _____

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