

Tennessee Health Link Opt-Out Form

Complete this form when a member requests to opt out of Health Link.

Please note: The date of member's request to opt out of Health Link is the effective date.

Section 1: member information
Member name:
DOB:
Legal guardian's name (if younger than age 18):
Amerigroup Community Care/TennCare ID:
Phone:
Section 2: Health Link provider information
Provider name:
Provider ID:
Phone:
Fax:
Name of requestor:
Section 3: signature
Date of member's opt-out request: _____
Member signature: _____
Provider signature: _____
I recognize by signing this form that I am agreeing to no longer receive Health Link services. I recognize that if I choose to participate in Health Link services again, I can do so by contacting Amerigroup at 1-800-600-4441 or by contacting my local community mental health center.
Please fax completed opt-out form to Amerigroup at 1-844-756-4605.