

12/09/10



HFS Case #: 2958746532158759



JOHN DOE
12358 MAIN STREET
OHIO GROVE, IL 61231-0000

Dear Mr(s). JOHN DOE:

A few weeks ago, the Illinois Department of Healthcare and Family, through the Illinois Client Enrollment Broker (ICEB), sent you an enrollment packet about picking a health plan and a Primary Care Provider (PCP) as a medical home for you and your family members listed below. We have not received the medical home choices you want to pick for you and your family.

Your medical home is the place you will go first when you need healthcare or are sick. Your PCP is the doctor, nurse or other healthcare provider at your medical home who takes care of you and your family. Your PCP will get to know you well. That way, you and your family get the quality healthcare you need to stay healthy. Even if you are healthy and never get sick it is good to have a medical home.

The Health Plans you can choose from are all good choices. They are:

Illinois Health Connect - 01 Meridian Health Plan - 04

Please send us your choices for each person named below by 02/11/11. If we do not hear from you by that date, you and your family members will be assigned to the health plan and PCP listed below.

Table with 4 columns: Name of Member, Recipient ID #, Health Plan, PCP Name. Row 1: John Doe, 123456789, Illinois Health Connect, James Smith

To pick a PCP and health plan today:

- Complete and mail the enclosed enrollment form in the envelope provided. OR
Call us at 1-877-912-8880. If you use a TTY, call 1-866-565-8576. The call is free. We will give you information to help you choose a PCP and health plan. Enrolling by phone is the quickest and easiest way to enroll! OR
Go to our Website, www.illinoisceb.com, and click on "Enroll".

After you choose your PCP and health plan, you will receive a confirmation letter in the mail.

You can get information in another language or format (like audiotape).
Free interpretation services!
Call 1-877-912-8880 (TTY 1-866-565-8576)
Hay información en español. ¡Servicio de interprete gratis!
Llame al 1-877-912-8880 (TTY 1-866-565-8576)



## ENROLLMENT FORM

### RECIPIENT INFORMATION

**HEALTH PLAN** and a **PCP** (Primary Care Provider) for each person listed below.

NAME	RECIPIENT ID	DATE OF BIRTH	HEALTH PLAN ID NUMBER	PCP NAME & ID NUMBER	PCP ADDRESS
John Doe	123456789	04/03/81	_____	_____	_____

### HEALTH QUESTIONS

Please answer the following health questions. Your answers will help your doctor provide quality healthcare to you and your family. The answers are confidential and will not affect your enrollment.

1. Is anyone listed above pregnant? \_\_\_\_ YES \_\_\_\_ NO

NAME(S)

DUE DATE(S)

\_\_\_\_\_  
\_\_\_\_\_

2. Does anyone listed above have asthma, diabetes or any other chronic illness? \_\_\_\_ YES \_\_\_\_ NO

NAME(S)

ILLNESS(ES)

NAME OF DOCTOR(S)

\_\_\_\_\_  
\_\_\_\_\_

3. Does anyone listed above go to a specialist for ongoing care? \_\_\_\_ YES \_\_\_\_ NO

NAME(S)

NAME OF SPECIALIST(S)

\_\_\_\_\_  
\_\_\_\_\_

### CONTACT INFORMATION AND SIGNATURE

• If you received help filling out this form from a health plan marketing representative, please check the boxes that apply:

- Name and ID number of marketing representative that helped me: \_\_\_\_\_
- I was educated on all of my health plan choices.
- I have picked the health plan and PCP for each family member listed above.

• Please fill out your current address and phone number in case we need to contact you about this form. The Head of Case must sign and date.

\_\_\_\_\_  
My Current Telephone Number

\_\_\_\_\_  
My Current Street Address

\_\_\_\_\_  
My Current City, State, Zip Code

\_\_\_\_\_  
My Printed Name

\_\_\_\_\_  
My Signature

\_\_\_\_\_  
Date Signed