

12/09/10



HFS Case #: 2958746532158759



JOHN DOE
12358 MAIN STREET
DES PLAINES, IL 60016-0000

Dear Mr(s). JOHN DOE:

The Illinois Department of Healthcare and Family Services (HFS), through the Illinois Client Enrollment Broker (ICEB), is sending you this enrollment packet to let know you about the choices you have for healthcare. At this time, you must pick a health plan and primary care provider (PCP) as a medical home for you and the family members listed below.

A medical home is the doctor's office or clinic where you go first when you need healthcare or are sick. You will see your PCP at your medical home. Your PCP is the family doctor, nurse or other healthcare provider at your medical home who takes care of you and your family. Having a medical home means you and your family get the quality healthcare you need to stay healthy.

Please read everything in this packet, including the Illinois Client Enrollment Broker Information Guide. It will help you make the best choice for you and your family.

The Health Plans you can pick from are all good choices:

Illinois Health Connect - 01 Harmony Health Plan - 02 Family Health Network - 03 Meridian Health Plan - 04

Table with 2 columns: Name of Member, Recipient ID #. Row 1: John Doe, 123456789

HOW TO ENROLL

- 1. PICK A HEALTH PLAN: Read the enclosed "Illinois Client Enrollment Broker Information Guide" for help in picking a health plan.
2. PICK A PCP: Choose a PCP in the health plan you picked. Read the enclosed "Enrollment Tips" for help in picking a PCP.
3. ENROLL: There are three ways to enroll.

BY PHONE: Call the Illinois Client Enrollment Broker at 1-877-912-8880 (TTY 1-866-565-8576). The call is free.

Enrolling by phone is the quickest and easiest way to enroll!

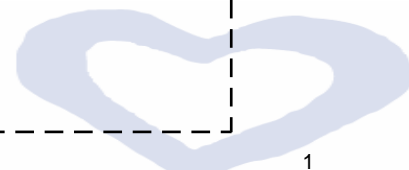
BY MAIL: Complete and mail the enclosed enrollment form in the envelope provided.

ONLINE: Go to the Illinois Client Enrollment Broker website at www.illinoisceb.com and click on "Enroll".

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

Please pick a health plan and PCP for each person named above by 02/11/11. You do not have to pick the same health plan or PCP for every member of your family. If we do not hear from you by that date, we will pick a Health Plan and PCP for you.

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