Enrollment Form

Complete this form after you have picked a health plan and a Primary Care Provider (PCP) for each person listed below. Follow these steps:

- **First** write the ID number of the health plan that you have picked for each person listed below in the Health Plan ID Number box. The health plan ID numbers are:

  Illinois Health Connect - 01 Meridian Health Plan - 04
- **Second** write the Primary Care Providers (PCP) provider ID number in the Provider (PCP) ID Number column. You can find this Provider ID Number by calling us at 1-877-912-8880. If you use a TTY, call 1-866-565-8576. The call is free. Or, go online at www.illinoisceb.com and click on "Pick a Provider."
- **Third** complete the health questions below.
- **Sign and date** the form.
- **Send** the form to us using the return envelope in this packet.
- If you want to enroll by phone, or have questions, call us at 1-877-912-8880. If you use a TTY, call 1-866-565-8576. The call is free.

Health Plan ID Numbers: Illinois Health Connect - 01 Meridian Health Plan - 04

NAME	HFS ID NUMBER	DATE OF BIRTH	HEALTH PLAN ID NUMBER	PROVIDER (PCP) ID NUMBER
John Doe	123456789	04/03/81	________	________

Sample

Please answer these questions. Your answers will help your PCP provide top quality health care for you and your family. The answers you provide will not affect your enrollment.

1. Is anyone listed above pregnant? If so, please list their name and due date.

   ____
2. Does anyone listed above have asthma, diabetes or any other chronic illness? If so, please list their name, the illness and the name of the doctor providing care for the chronic illness.

   ____

   ____
3. Does anyone listed above go to a specialist for ongoing care? If so, please list their name and the specialist name.

   ____

   ____

Please check the boxes below if you received assistance in completing this form.

☐ I was assisted in completing the enrollment form.

☐ I was educated on all of my health care choices.

____
Name, title and ID of person that assisted you in completing the form.

I have picked the health plans and Primary Care Providers for each family member listed above.

____
My Signature

____
Date

____
My Phone Number