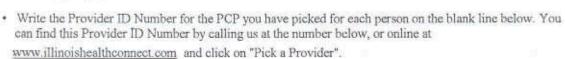
Illinois Health Connect Enrollment Form

Complete this form after you have picked a Primary Care Provider (PCP) for each person listed below.

Follow these steps:



- · 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 1-877-912-1999. If you use a TTY, call 1-866-565-8577. The call is free.

NAME	RECIPIENT ID NUMBER	DATE OF BIRTH	PROVIDER 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 enrollmen	it.
1. Is anyone listed above pregnant? If so, please list their nan	ne and due date.
Does anyone listed above have asthma, diabetes or any othe illness and the name of the doctor providing care for the chr.	
Does anyone listed above go to a specialist for ongoing care	e? If so, please list their name.
I have picked the doctors or other health professionals above to members listed above.	o be the Primary Care Providers for my family
My Signature	Date



My Phone Number