

PLEASE FAX THIS FORM TO 412-456-1096



CONSUMER HEALTH COALITION REFERRAL FORM

By filling out this form, I give Consumer Health Coalition permission to contact me for help with applying for and/or renewing my Medical Assistance or CHIP health insurance for my child/children under age 19.

Name: _____

Complete Mailing Address _____

Home Phone # _____

Cell Phone # _____

Alternate Phone # _____

Language of preference _____

Form Completed by (Agency Name / Staff Member) _____ / _____

Date Completed _____

Signature of Staff Member or Consumer _____

Please call consumer because she is pregnant and needs help applying for health insurance for her newborn – Expected Due Date: _____

Please complete an application for Medicaid or CHIP with the consumer
Number of uninsured children in household _____

Please follow-up on the status of application for children (Already completed application for Medicaid / CHIP)

Please follow-up to help consumer with their Medicaid/CHIP renewal

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