PLEASE FAX THIS FORM TO 412-456-1096

consumer health coalition
raising health

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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