United Health Services
Covering Kids & Families of United Health Services

Authorization for Referral to
Covering Kids & Families of United Health Services

Client Name: _____ Date of Birth: _____

Mailing Address: _____

Phone #: _____ Alternate Phone #: _____

Insured? Yes No Not Sure (circle one) by whom: _____

_____ (initial) I authorize _____ to disclose information to the following agency for the purpose of enrolling in affordable health coverage.

Agency Name: **Covering Kids & Families of United Health Services**
Address: 6910 North Main Street, Building 9, Granger, IN 46530
Phone #: 574-247-6047 Fax #: 574-247-6060
Information to be released: Client name, address, date of birth and phone number(s), Presumptive Eligibility and/or insurance status, and MCE chosen/Insurance Company.

I allow Covering Kids & Families of United Health Services to contact me
(initial)_____ by phone _____ by text message or _____by mail.

By signing below, I understand that I have given approval for a Navigator from Covering Kids & Families of United Health Services to contact me regarding my enrollment in or questions on the Federal Marketplace, Medicaid, the Healthy Indiana Plan, CHIP or Hoosier Healthwise.

Signature of Client:_____Date:_____
Or if under 18
Signature Legal Guardian:_____

Print:_____ Date: _____

Relationship to Client:_____

Using a cover sheet with no client information on it, please fax this to 574-247-6060. An Indiana Navigator will contact the client within 3 business days. Please call 574-314-5430 with questions. Appointments may also be made on uhs-in.org/insure in English or Spanish.