



**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.