



CONSENT TO CONTACT FORM

The following resident and/or resident's authorized representative has expressed interest in receiving information about the benefits and services available through the Institutional Special Needs Plan (ISNP).

Email completed form to: ISNPReferral@chs-corp.com Or fax to: (513) 605-6829

Facility Name:
Facility Staff Name (printed):
Resident's Legal Name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Resident's Length of Stay: Date Admitted to Nursing Facility: <input type="checkbox"/> If admission is less than 90 days, does the resident expect to reside within the facility for 90 + days.
Resident has been deemed incompetent to make decisions/sign for themselves? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide any additional details about this Consent to Contact Form that would be helpful for the Sales Agent to know about the resident and/or their authorized representative:

Resident or Authorized Representative Contact Information:

Who should the Health Plan contact to discuss plan benefits and services information?

Resident Authorized Representative

If authorized representative, what is the relationship to Resident:

Family Member POA Guardian Other:

Authorized Representative's Name:

Phone Number:

Email address (optional):

Upon submission of this Consent to Contact Form, I attest the information provided above is true and accurate to the best of my knowledge based on the information available to me at the time of completing this Consent to Contact Form. The resident has also been made aware that they are being transferred to a licensed agent who can enroll him or her into a new plan.

Facility Staff Signature:

Date:

Questions?

Call anytime between 8 a.m. – 8 p.m.
Mon – Sun Oct 1st through March 31st

8 a.m. – 8 p.m. Mon – Friday, April 1st
through Sept 30th

CCA: (866) 212-4582, TTY/TDD 711
WVSA: (866) 250-6352, TTY/TDD 711