Questions? Call 1-800-964-2777

MANAGED CARE ENROLLMENT FORM

STAR Program

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

Head of Household Name: HeadName
Street Address: HeadAdd1 HeadAdd2
City: HeadCity, State: HeadState, Zip: HeadZip
Phone Number: HeadPhone
County: County

Write Name of Other Health Insurance Below

Other Health Insurance Company: _____
Company Street Address: _____
Company City: _____
State: _____
Zip: _____
Policy Holder: _____
Policy Number: _____

If any preprinted information is wrong, cross it out and write in the correction.

Write in Health Plan Names, PCP Names and Phone Numbers From The Health Plan Directories.

Recipient Name (Last, First, MI) *If recipient is pregnant, circle name.*	**BEN1LNAME** **BEN1FNAME** **BEN1MNAME**	**BEN2LNAME** **BEN2FNAME** **BEN2MNAME**	**BEN3LNAME** **BEN3FNAME** **BEN3MNAME**	**BEN4LNAME** **BEN4FNAME** **BEN4MNAME**
Date of Birth	**BEN1BDAY** MM/DD/YY	**BEN2BDAY** MM/DD/YY	**BEN3BDAY** MM/DD/YY	**BEN4BDAY** MM/DD/YY
Medicaid Number or SSN	**BEN1CIN**	**BEN2CIN**	**BEN3CIN**	**BEN4CIN**
Health Plan Name *Enter 1st and 2nd Choice*	1st 2nd	1st 2nd	1st 2nd	1st 2nd
Primary Care Provider Name *Enter 1st and 2nd Choice*	1st 2nd	1st 2nd	1st 2nd	1st 2nd
PCP Phone Number	1st 2nd	1st 2nd	1st 2nd	1st 2nd
Other Health Insurance?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Please check one of the boxes to tell us the primary language spoken:	☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese Other:	☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese Other:	☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese Other:	☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese Other:
Please answer the following questions for adults:				
1. Do you need help throughout the day and/or night to carry out daily living activities?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
2. Do you need special equipment to help you get around?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
3. Do you take more than five prescriptions each day?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Please answer the following questions for children:				
1. Does your child need more medical care, mental health care or special education services than most his/her age?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
2. Are your child's daily activities often limited because of medical or mental health care problems?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
3. Does your child regularly use special health care equipment?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
4. Does your child need regular medical care that should not be stopped?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
5. Does your child have medical or mental health problems that cause him/her to be sick often?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

If more than four recipients, write them on the back of this form.

I (the client) agree that I will go only to my Primary Care Provider (PCP) for all Medicaid services unless I am referred to another Provider by my PCP, or unless I need emergency care, family planning or other non-referral services listed in my Health Plan Member Handbook. For persons under age 21, PCP approval is not required for Texas Health Steps Dental checkups and/or dental treatment.

You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions.) If the information is wrong, you can ask us to correct it. The Health and Human Service Commission has a method for asking for corrections. You can find it in Title 1 of the Texas Administrative Code, sections 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact MAXIMUS, Enrollment Broker. You can write them at P.O. Box 149219, Austin, TX 78714-9965. You can also call them at 1-800-964-2777.

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Head of Household Signature Date

ESPAÑOL AL OTRO LADO

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