ACA CHECKUP FORM

NAME: ____

ADDRESS: ____

CITY: _________________________ **ST:**_____ **ZIP:** _________________

PHONE: _______________________ **COUNTY:**_____________________

Income of Enrollee: _____________________________________

SSN: ________________________ **DOB:** _________________________

EMAIL: ____

Dependents Names: (Spouse)________________________________

Spouse Income:________________ **DOB:**________________ **M/F**_____

Children:

C1) __________________________ **DOB** _______ **M/F Income**________

C2) __________________________ **DOB**________ **M/F Income** _______

C3) __________________________ **DOB**________ **M/F Income**_______

Members not being covered: ________________________________

PLANS TO PRESENT:

PLAN#: ____

Full Cost:_____________ **Subsidy:**_____________ **Client Prem:**_________

PLAN#: ____

Full Cost:_____________ **Subsidy:**_____________ **Client Prem:**_________

ACA Checkup Form Cont'd

PCP: ______________________________ ProviderID# ____________________

ADDRESS: __________________________ PHONE: _______________________

City: ___________________________ State: _______ Zip: ________________

Specialist (1)__________________________ Ph#____________________

Address:____

Specialist (2)__________________________ Ph#____________________

Address:____

Specialist (3)__________________________ Ph#____________________

Address:____

Specialist (4)__________________________ Ph#____________________

Address:____

Prescriptions: ☐ Diabetic ☐ Heart Problems

App Confirmation Code:____