State of Illinois
Department of Healthcare and Family Services
Department of Human Services
Illinois Medicaid Redetermination

<Name>
<Address>
<City, State ZIP>

<Barcode>

<Letter Date>

Case ID: <Case ID>

Dear <Name>,

It is time to renew your medical coverage!
It's time for renewal, also known as "redetermination" or "re-de."

<Special Message Text>

Here's what to do

1. Answer all questions on this form.
2. Sign this form at the bottom of **page <3>**.
3. Attach all proofs of income and expenses and other proofs we ask for.
4. Send your signed form and all proofs by **<Due Date>**.

Send your form and proofs to us one of these ways:

- **Fax** your form and proofs to 1-855-394-8066
- **Mail** your form and proofs in the envelope that we sent you
- **E-mail** your form and proofs to HFS.medredes@illinois.gov

Your medical benefits may end if you do not send your proofs by <Due Date>.

Call us at 1-855-458-4945 (TTY: 1-855-694-5458) if you cannot send everything on time or if you have questions. We may be able to help you get the proofs you need.

Thank you,
Illinois Medicaid Redetermination

State of Illinois
Department of Healthcare and Family Services
Department of Human Services
Illinois Medicaid Redetermination

<Barcode>

Case ID: <Case ID>

Medical Renewal Form

1. Do these people still live with you?

<MemberName>	<MemberDOB>	☐ Yes ☐ No
<MemberName>	<MemberDOB>	☐ Yes ☐ No
<MemberName>	<MemberDOB>	☐ Yes ☐ No
<MemberName>	<MemberDOB>	☐ Yes ☐ No

2. Tell us about anyone else who lives with you:

Name *First, Middle, Last, Suffix (Jr., Sr., II or III)*	**Date of birth** *(month/day/year)*	**Relationship to you** *(for example: spouse, child, parent)*
Name:	Date of birth:	Relationship:
Name:	Date of birth:	Relationship:
Name:	Date of birth:	Relationship:
Name:	Date of birth:	Relationship:

3. Is anyone who lives with you pregnant?

If yes, name: _____ Due date: _____ Expected number of babies: _____

4. Did you or anyone living with you get new health insurance in the last year? ☐ **Yes** ☐ **No**

If yes, name of insurance plan: _____ Policy number: _____

Who is covered by this health insurance? _____

5. Will you or anyone who lives with you file a federal income tax return *next year* to report income earned *this year*? ☐ **Yes** ☐ **No**

If yes, name of person filing tax return: _____

If this person will ***file jointly with a spouse***, write name of spouse: _____

If this person will ***claim dependents*** on the tax return, write name(s) of dependents:

_____ _____

_____ _____

Questions? Call **1-855-458-4945** (TTY: 1-855-694-5458). The call is free!
Monday to Friday from 7 a.m. to 9 p.m. and Saturday from 8 a.m. to 1 p.m.
E-mail us at **HFS.medredes@illinois.gov** or send a fax to 1-855-394-8066.
Tenemos información en español. ¡Servicio de intérpretes gratis!
Llame al 1-855-458-4945.

[MODE1]

12/13 - [LT] - [LN] - [PM] - [NC]
[FILENAME] - [LETTERID]
[MAILINGNAME] - [BIFILEID]

6. Can you be claimed as a dependent on anyone's tax return? ☐ **Yes** ☐ **No**

If yes, name of person: _____ Relationship to you: _____

7. Do you and everyone living with you still get this income from these sources?

Salary, wages, and tips for everyone *(total before taxes are taken out)*	Total per month: **$ <amount>** Is this correct? ☐ Yes ☐ No
Self-employment income for everyone *(profit once business expenses are paid)*	Total per month: **$ <amount>** Is this correct? ☐ Yes ☐ No
Unemployment for everyone	Total per month: **$ <amount>** Is this correct? ☐ Yes ☐ No
Social Security for everyone	Total per month: **$ <amount>** Is this correct? ☐ Yes ☐ No
Pension or retirement income for everyone	Total per month: **$ <amount>** Is this correct? ☐ Yes ☐ No
Spousal support received by everyone	Total per month: **$ <amount>** Is this correct? ☐ Yes ☐ No
Interest or investment income for everyone	Total per month: **$ <amount>** Is this correct? ☐ Yes ☐ No
Rental fees or royalties for everyone	Total per month: **$ <amount>** Is this correct? ☐ Yes ☐ No

➡ ***If you checked no*** *for any income, write the correct amount in the next section.*

8. Do you or anyone living with you get *other* income? *Check all that apply.*

☐ Salary, wages, and tips	How much?	How often?
☐ Self-employment	How much?	How often?
☐ Unemployment	How much?	How often?
☐ Social Security	How much?	How often?
☐ Pension or retirement income	How much?	How often?
☐ Interest or investment income	How much?	How often?
☐ Rental fees or royalties	How much?	How often?
☐ Spousal support received	How much?	How often?
☐ Other: _____	How much?	How often?

➡ *Attach proof of the amount for any income received in the last 30 days.*

9. Do you or anyone living with you pay any of these expenses? *Check all that apply.*

☐ Spousal support paid to someone else	How much?	How often?
☐ Student loan interest paid	How much?	How often?
☐ Other: _____	How much?	How often?

➡ *Attach proof of all expenses paid in the last 30 days.*

10. We also need these proofs from you:

☐ Copy of a Social Security card for **<MemberName>**

☐ Other: _____

11. Read and sign below:

- I understand that officials in charge of my health benefits may check all information on this form.
- I understand they may check my information electronically. If they ask for my help checking information, I must cooperate.
- I understand that anyone who knowingly lies or provides untrue information, or arranges for someone to knowingly lie or provide untrue information, or intentionally misuses the health benefits card issued by the State of Illinois, may be committing a crime which can be prosecuted or punished under federal law, state law, or both.
- If the Illinois Department of Healthcare and Family Services pays medical bills for me, the State of Illinois may collect my medical support payments instead of me.
- I am signing this form under the penalty of perjury. That means the information I have provided on this renewal form is true to the best of my knowledge, and I may be punished under law if I provide false or untrue information.

_____ _____

Your signature Today's date

12. Remember! Make sure you answered all questions and signed the form.

➡ Send this form to us with all proofs by **<Due Date>.**