

# Enrollment Reinstatement Request Form

# Requestor Information

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| Name: | Title: |
| Email: | Company HIOS ID: |
| Company Name:  | Date of Request (mm/dd/yyyy):  |

# Enrollment Information

To request the reinstatement of a cancelled or terminated enrollment please provide the following information. Use one Enrollment Reinstatement Request Form per policy.

**NOTE**: Do not provide names, Social Security Numbers, addresses, phone numbers, email addresses, or other identifying information; do not include any information related to claims or medical goods/services.

When your request is processed SSHIX will create a corresponding Case in Carrier Connector to confirm the member-level details of individual enrollees. Reinstatement will not occur until confirmation is received.

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| Exchange-Assigned Policy ID:  | Exchange-Assigned Subscriber ID:  |
| Coverage Begin Date for Reinstatement (mm/dd/yyyy):  | Coverage End Date for Reinstatement (mm/dd/yyyy):  |
| Number of Enrolled Members at time of Cancellation or Termination:  | Number of Members to be reinstated:  |
| Circumstances of Cancellation/Termination (please omit PII or PHI):  |
| Circumstances of Reinstatement Request (please omit PII or PHI):  |

# Submission

Please do a ‘Save As’ and add the name of your company and the date of your request to the filename. Return completed forms in electronic format (do not print/scan) to reconsupport@exchange.nv.gov; do not include PHI or PII in the body of the email.