

# 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](mailto:reconsupport@exchange.nv.gov); do not include PHI or PII in the body of the email.