

## Dual Eligible Special Needs Plan (DSNP) Enrollment Fax Cover Sheet

Date: \_\_\_\_\_

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<b>To: DSNP Enrollment Department</b>	<b>Fax: (800) 871-5281</b>
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Agent Name:	Agent ID:
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### Select Document(s) Being Faxed

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4. \_\_\_\_\_
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### **URGENT Missing Information:**

Member Name: \_\_\_\_\_

ATTENTION ConnectiCare Employee: \_\_\_\_\_

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