access health CT

Broker Support Request Form (BSR)

Please complete and email to: AHCTBrokerSupport@ct.gov

PLEASE NOTE REQUIRED FIELDS		
Date: ***(Required)***	**Case Number:**	**Contact Center SR #:**
Submitter / Broker Name ***(Required)***	**Certification #:**	**Contact phone Number:** ***(Required)***
Applicant Name: ***(Required)***	**Applicant Address:** ***(Required)***	
Applicant Phone Number: ***(Required)***	**Applicant Alternate Phone Number:**	**Applicant User ID:**
SSN: ***(Required)***	**Date of Birth:** ***(Required)***	**Coverage Effective Date:** ***(Required)***
Last Application ID #: ***(Required)***	**Carrier Name:** ***(Required)***	**Plan Name:** ***(Required)***
Names of Additional Members on the Same Policy: ***(Required, if applicable)***		
Is this request a medical emergency? (Y/N)	**Appeal Type:**	**EDI Transmission Date:**
Are any household members on Medicaid? (Y/N)	**Subsidy Amount:**	**Date Sent to Xerox:**
Issue / Support Request Description: ***(Required)***		

	JIRA Ticket #:	**Date Opened:**	**CR/Incident:**	**Date Closed:**