Intercounty Transfer Referral Form

Proposed Transition Date: ____/____/_____

PA Independent Enrollment Broker

Participant Information

First Name: _____ Last Name: _____

Date of Birth: _____ Social Security Number: xxx-xx-_____

Medicaid ID Number: _____ Select Current MCO:

- ☐ PA Health and wellness
- ☐ UPMC Health
- ☐ AmeriHealth Caritas

Current Address/ Service Coordination Information

Current Address: _____ Current Service Coordinator: _____

Current County: _____ Current County: _____

Email Address: _____ Email Address: _____

Home Phone: _____ Phone number: _____

Cell Phone: _____

Future Address/ Service Coordination Information

Future Address: _____ Future Service Coordinator: _____

Future County: _____ Contact Name: _____

Email Address: _____ County: _____

Home Phone: _____ Email Address: _____

Cell Phone: _____ Phone Number _____

Emergency Contact Information

Emergency Contact Name: _____	Emergency Contact Name: _____
Cell Phone Number: _____	Cell Phone Number: _____
Home Phone Number:	Home Phone Number:

Signature of person completing form: _____ Date:___/___/_____

P.O. Box 61560
Harrisburg, PA 17106

Call us toll free at
1-877-550-4227

Send a fax to
1-888-349-0264

Email us at
paieb@maximus.com