Nursing Facility Referral Form

PA Independent Enrollment Broker

For residents in the Southwest zone who are applying for Medical Assistance or need choice counseling.

Participant information

First name: _____ Last name: _____

Date of birth: __ __ / __ __ / __ __ __ __ Social Security Number: XXX-XX-__ __ __ __

Medicaid ID number: _____ Email address: _____

Address (street, city, state, ZIP Code): _____

Home phone: _____ Cell phone: _____

Authorized representative

1. Tell us about the authorized representative, if known.

   Name of authorized representative: _____

   Address (street, city, state, ZIP Code): _____

   Phone: _____

   Type of authorized representative (check one):

   ☐ Power of attorney ☐ Community spouse ☐ Other

2. Tell us about another authorized representative, if known.

   Name of authorized representative: _____

   Address (street, city, state, ZIP Code): _____

   Phone: _____

   Type of authorized representative (check one):

   ☐ Power of attorney ☐ Community spouse ☐ Other

Nursing facility staff person

First name: _____ Last name: _____

Name of nursing facility: _____

Address (street, city, state, ZIP Code): _____

Phone: _____ Email address: _____

Name of person completing form: _____ Title: _____

Signature: _____ Date: __ __ / __ __ / __ __ __ __

Fill out this PDF and print it. Or print the blank form and fill it out by hand. Send this form by mail, fax or email. If you have questions, call us at **1-877-550-4227** (TTY: 1-877-824-9346). The call is free.

P.O. Box 61560
Harrisburg, PA 17106

Call us toll free at
1-877-550-4227
(TTY: 1-877-824-9346)

Send a fax to
1-888-349-0264

Email us at
paieb@maximus.com