Intercounty Transfer Referral Form

Proposed Transition Date: ____/____/________

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 County: ____________________________________

Email Address: ____________________________________

Home Phone: ____________________________________

Cell Phone: ____________________________________

Current Service Coordinator: ____________________________________

Current County: ____________________________________

Email Address: ____________________________________

Phone number: ____________________________________

Future Address/ Service Coordination Information

Future Address: ____________________________________

Future County: ____________________________________

Email Address: ____________________________________

Home Phone: ____________________________________

Cell Phone: ____________________________________

Future Service Coordinator: ____________________________________

Contact Name: ____________________________________

County: ____________________________________

Email Address: ____________________________________

Phone Number ____________________________________

Emergency Contact Information

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