



PA Independent Enrollment Broker

Referral Guidelines

1. To refer an individual, please complete this form and return it to Pennsylvania Independent Enrollment Broker (PA IEB) via **fax** or **secure email**.
2. To initiate a secure email exchange, please email PAIEB@maximus.com to indicate you have a document containing Protected Health Information (PHI) or Personally Identifiable Information (PII) that you would like to send via email. PA IEB will return your email and initiate a secure email portal.
3. If a document containing Protected Health Information (PHI) or Personally Identifiable Information (PII) is sent to PA IEB in a method that is not secure then the document will not be opened.
4. After the referral is received the individual will be contacted via phone within 1-3 business days. PA IEB may use an automated dialer to make contact with these individuals. Please note that an application will not begin until the individual expresses to IEB staff interest in applying and the individual has Medical Assistance or completes and returns an application for financial eligibility for Long Term Services to PA IEB.

Applicant Information

First Name:	_____	Last Name:	_____
Recipient ID No:	_____	Phone No:	_____
	(Medicaid Recipients Only)		
Alternate Phone:	_____	Street Address:	_____
Email Address:	_____	City, State, Zip:	_____
Date of Birth:	_____	Social Sec #:	_____

Please contact the additional contact below to begin process. *Note: applicant must sign consent below*

Additional Contacts (Add another page, if needed)

Contact Name or Entity: _____ Contact Type (Family, POA, AAA, Social Worker): _____ Phone Number: _____ <i>Signature of applicant authorizing sharing of information with this contact:</i> _____	Contact Name or Entity: _____ Contact Type (Family, POA, AAA, Social Worker): _____ Phone Number: _____ <i>Signature of applicant authorizing sharing of information with this contact:</i> _____
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Physician Information

Physician Name: _____	Physician Address: _____
Physician Phone: _____	Street Address: _____
Physician Fax No: _____	City, State, Zip: _____

Nursing Home Transition Program

NHT Coordinator: _____ Agency: _____

Area Agency on Aging Use Only

Case Indicator: _____
PA600L Included: <input type="checkbox"/>



P.O. Box 61077
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