

The New Participant F/EA Referral Form should only be used when the participant is transferring from “Options” to waiver or when the PPL Web Portal is down for maintenance or temporarily unavailable.

REFERRING AGENCY

Date:	Service Coordinator:	Phone:
Agency:	Service Coordinator Supervisor:	Alternate Phone:
Email address:	Fax #:	
Program:	<input type="checkbox"/> OBRA Waiver <input type="checkbox"/> Attendant Care Waiver <input type="checkbox"/> Aging Waiver <input type="checkbox"/> Act 150 Waiver <input type="checkbox"/> CommCare Waiver <input type="checkbox"/> Independence Waiver	
Referral Type: <input type="checkbox"/> New <input type="checkbox"/> Transfer: <i>(Please Provide Transferring Agency)</i> _____ <input type="checkbox"/> Options Transfer: <i>(Please Provide Options F/EA)</i> _____		

NEW PARTICIPANT INFORMATION

Last Name:	First Name:	Medicaid ID (10 Digit) #:	
SS Number:	Date of Birth:	Gender:	ICD-9 code:
Physical Address:			
City:	State:	Zip:	County of Residence:
Mailing Address <i>(if different from Physical Address above)</i> :			
City:	State:	Zip:	Primary Language:
Phone:	Alternate Phone:	Email Address:	
Emergency Contact Name:			Emergency Contact Phone:

COMMON LAW EMPLOYER INFORMATION, IF OTHER THAN PARTICIPANT

Last Name:	First Name:	SS Number:	
Physical Address:			
City:	State:	Zip:	Relationship to participant:
Phone:	Alternate Phone:	Email address:	

SUBMIT FORM: Fax completed form to: **855-858-8158** or e-mail form to: padpw-oltl@pcgus.com. If you have any questions please call PPL Customer Service: 877-908-1750.