# REFERRAL FORM

the P.A.L.
Personal Alert Link
*In-Home Medical Alarms & Medication Management*

Fax: 1-512-383-5993
Website: www.thepal.com
Call: Toll Free 1-866-640-4384

Date: _____

(Please use one of the following referral methods)

## Referral Source

Your Name _____ Your Phone _____

Your Company/Agency Name _____

**Please let me know the status of my referral!**

Phone:_____Fax:_____ E-mail:_____

## Customer Being Referred

☐ Ready to order ☐ Requests information

_____
First/Last Name

_____
Address

_____ _____ _____
City State Zip

_____ _____/_____/_____
Phone Date of Birth

**Customers Contact Person (If different than customer)**

_____ _____
First/Last Name Relationship to Customer

_____ _____
Phone Best Date and Time to Call

## Medicaid Special Requests

**Medicaid or Social Security #**_____

To qualify for Medicaid payment the customer must be able to answer yes to all of the following 3 questions:

☐ Yes, the customer is a current Medicaid recipient.
☐ Yes, the customer is home alone more than 8 hours per day.
☐ Yes, the customer has home telephone service.

Note: Customer information must appear as it is printed on the recipients Medicaid card. Complete above customer information along with Medicaid number. **We will immediately submit your patients request for Medicaid funding upon receipt of this referral form. Due to a waiting list for Medicaid eligibility, please encourage your patient to pay for the PAL service while waiting for approval.**

**Questions: Please contact a P.A.L. Personal Alert Link representative at: 866-640-4384**

SLS-MK-IF-021308-086