## GOVERNMENT OF THE DISTRICT OF COLUMBIA Department of Health Care Finance



## REFERRAL FORM FOR DME MEDICAL ASSISTIVE DEVICES AND SERVICES (DME MADS)

Instructions: This form is to be used in conjunction with the Beneficiary, their family, or Authorized Representative and may be used to request either Personal Emergency Response System (PERS) services or a Medication Management Device (MMD) services (or both services simultaneously).

☐ New Referral ☐ Reauthorization of Existing Services ☐ Transfer Request	
Beneficiary Information	
Beneficiary Name: N	Medicaid ID: Program Code:
Address: T	Felephone Number:
	Date of Birth:
Beneficiary's Physician: Phy	ysician telephone:
Physician NPI, if known: Phy	sician fax number:
Special Notes for Installation:	
Provider Selection (select 1):    Alert Medical Alarms – 02  Lifeline Systems – 027850295	20967561 □ Best Buy Health – 037965419 □ Guardian – 068565892
Service Selection:   Landline PERS   Wireless PERS (select all that apply)	□ Mobile PERS □ Medication Management Device
If Medication Management Device, please list a contact who	o can assist with installation and loading:
Referral Information	
Referrer's Name: Re	eferrer's Telephone Number:
Relationship to Beneficiary: Re	eferrer's Fax Number:
Has this person been assessed with the interRAI HC in the la If no, is clinical documentation to justify the referral atta	•
Does the Beneficiary work with a Home Health Agency?	Yes No
If so, please include the name of the Home Health Agency: _	
Provider Acceptance	
Provider Acceptance	
Date 719A form submitted: Authoriza	ntion Number:

Please submit this form to an approved DME MADS provider via secure email to the following:

- Alert Medical Alarms: intake@alertmedicalalarms.com
- Best Buy Health: <u>Referrals-CST@bestbuy.com</u> or Secure Fax: 1-800-325-5145
- Guardian Medical Monitoring: <u>sf-hc@guardianmedicalmonitoring.com</u>
- Lifeline Systems: governmentservices@lifeline.com