Keystone First

FAST FACTS Important Information for our Providers

Environmental Lead Investigation (ELI) Process

All Medicaid members are required to be tested for lead levels starting at 9 months of age, as well as other ages based on history and risk assessment. Keystone First members with a venous lead draw showing an elevated blood level of ≥5 µl/dl, are eligible for an environmental lead investigation.

Keystone First has contracted with Accredited Environmental Technologies (AET), to provide environmental lead investigation services to our members. We are in contract discussions with other lead investigation service providers and will keep you updated when other entities join our network.

How to refer a Keystone First member for an ELI:

1. Complete the attached AET form*
2. Fax to AET at 610-891-0559
3. AET will complete the ELI

*The AET referral form is available at www.keystonefirstpa.com→Providers→Resources→ EPSDT→EPSDT forms and administration

For any questions about the AET form or the AET investigation process, please contact Eric Sutherland at AET at 1-800-9696-AET.

Thank you for your continued commitment to the health and well-being of our members.

Accredited Environmental Technologies, Inc.

EBL/EBI Investigation Referral Form Date:_____

Child/Children Elevated Blood Level Information:

Child's Name: _____ Child's DOB_____ (M/F)

All Reported EBL Levels/Date_____

Child's Name: _____ Child's DOB_____ (M/F)

All Reported EBL Levels/Date_____

Child's Name: _____ Child's DOB_____ (M/F)

All Reported EBL Levels/Date_____

Child/Children's Primary Address:_____

City/State:_____ Apt/Unit #:_____

Child's Secondary Address (if applicable): _____

Apartment or Single Family Home (circle one) _____# of Bedrooms _____# of Floors

Parent/Guardian Information:

Parent/Guardian Name: _____ DOB:_____

Address (if different than Child's): _____ Phone #: _____

Insurance Information: ***(Only required for 1 child if living in the same household. Please be sure to indicate which child information is for)***

Insurance Provider: _____

MA #/ID #: _____ Rx#/Auth#_____

Primary Care Physician (PCP) Information:

PCP Name: _____

Phone No.: _____ Fax No.: _____ Email Address: _____

Mailing Address: _____

**If PCP would like the final report mailed please provide mailing address otherwise AET will fax a copy once completed.*

Comments:_____

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