

Please fax completed/signed document to **877-756-3077**
 Please include all necessary documentation



HOME HEALTH REFERRAL ✚ FACE-to-FACE ENCOUNTER ✚ PHYSICIAN ORDER

Patient Name: _____	Fax: <u>877-756-3077</u>
Patient Phone: _____	Referral Date: _____
Patient Address/Facility: _____	DOB: _____
Contact Person: _____	Insurance Information: _____
	Contact Phone: _____

Face-to-Face Patient Visit Attestation

Required to support the need for Home Health Services

Please attach: ✚ Most recent office visit note, H&P or D/C Summary **that addresses the reason for home health**
 ✚ Face Sheet ✚ Med List

Medical Condition: At the encounter the patient exhibited the following clinical conditions which are related to the **reason for the home health services** _____

Clinical Findings that Support the Patient's Eligibility: Provide a summary of the clinical findings that support the patient's eligibility for the ordered home health services including a specific need for intermittent skilled nursing services and/or therapy services _____

Homebound: A patient is homebound if the absences from home require considerable and taxing effort and are for medical reasons or religious services OR are infrequent or of short duration when for other reasons. A patient is homebound when he/she has functional, emotional, cognitive or medically ordered restrictions and requires assistance to leave the home.

What condition(s) caused the patient to be homebound?	What assistive devices does patient need to use now?	Describe the effort needed for patient to leave home:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician Orders for Home Health Services

- RN for _____
- PT for _____
- ST for _____

Your patient will be admitted within 48 hours of receipt of your referral. If your patient needs to be admitted sooner, please indicate the date you would like care to start: _____

Additional Orders: _____

I certify that this patient is under my care and that I or a nurse practitioner/clinical nurse specialist/certified nurse-midwife or physician assistant working in collaboration with me or under my supervision, had a face-to-face visit encounter that meets the physician's face-to-face encounter requirements with this patient on _____ (date of visit)

Physician Name: _____

Physician Phone: _____ PECOS/NPI _____

Physician Signature: _____ Date: _____