A Caring Hand Home Care

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REFERRAL FORM

Please fax to: (904) 733-8776

Phone: (904) 733-8778

NAME:_____ **D.O.B.**_____

ADDRESS:_____ **PHONE:**_____

CITY/STATE:_____ **ZIP:**_____ **SS#:**_____

MEDICARE #:_____

INSURANCE PLAN (#1):_____ **POLICY #:**_____

INSURANCE PLAN (#2):_____ **POLICY #:**_____

MEDICARE VERIFICATION OF FACE-TO-FACE ENCOUNTER

A "face-to-face encounter" (medical visit) is required for traditional Medicare patients within the 90 days prior to, or the 30 days following, the start of home care services.

CERTIFICATION DATE:

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on:

DATE:_____

I certify that, based on my findings, the following services are medically necessary home health services:

- ☐ Skilled Nursing
- ☐ Physical Therapy
- ☐ Medical Social Worker
- ☐ Psych/Behavioral Health
- ☐ Occupational Therapy
- ☐ Home Health Aide
- ☐ Speech Therapy

PRIMARY DIAGNOSIS / MEDICAL CONDITION:

The encounter with the patient was in whole, or part, for the following medical condition, which is the primary reason for home health care.

_____

CLINICAL FINDINGS:

My clinical findings support the need for the above services because:

_____

_____

HOME BOUND STATUS:

Further, I certify that my clinical findings support that this patient is homebound because:

_____

_____

Physician Signature:_____ Date of Signature:_____

Physician Printed Name:_____