

PATIENT REFERRAL FORM

NAME: _____ S.S.#: _____ / _____ / _____

ADDRESS: _____ D.O.B.: _____ / _____ / _____

PHONE: (_____) _____ - _____

INSURANCE

Plan #1: _____ Policy No.: _____ (e.g., Medicare)

Plan #2: _____ Policy No.: _____ (Secondary)

EMERGENCY CONTACT

Name: _____ Phone: _____

Address: _____

MEDICARE “FACE-TO-FACE ENCOUNTER” DOCUMENTATION

A “face-to-face encounter” (medical visit) is required only for Medicare patients within the 90 days prior to, or the 30 days following, the start of home care services in order for the services to be paid for by Medicare.

PRIMARY DIAGNOSIS & REASON FOR HOME HEALTHCARE REFERRAL: (please fax med history and med list) _____

CLINICAL FINDINGS TO SUPPORT THE NEED FOR SERVICES: _____

I certify that the patient is homebound (ie. absences from the home require considerable and taxing effort and are for medical reasons or religious services or of short duration because: _____

“FACE TO FACE ENCOUNTER” (DATE OF LAST MD APPT): _____ / _____ / _____

THE FOLLOWING SERVICES ARE MEDICALLY NECESSARY FOR HOME HEALTH CARE:

- Skilled Nursing Medical Social Work Nutrition Home Health Aides
- Physical Therapy Occupational Therapy Speech Therapy Certified Wound Specialist

CHECK BOX IF NEXT DAY VISIT NEEDED

PHYSICIAN SIGNATURE _____ **DATE** _____ / _____ / _____

MUST BE SIGNED BY A PHYSICIAN

VNSHOME HEALTH SERVICES

FAX: 788-2063

PHONE: 788-2345