MediCall Home Health Services

Referral for Home Health Services

FAX BACK TO (817) 439 – 6794 WITH YOUR COVER SHEET

Please provide the following information (or attach copy of demographic sheet/ insurance card)

Demographics

Patient Name: _____

Date of Birth: _____ ☐ M ☐ F

SS# _____

Address: _____

City: _____, TX ZIP: _____

Phone(s): _____

Alternate Contacts/ Phone(s): _____

_____

Main Reason for Home Health _____

_____

Referral Source

Primary Care MD _____

Phone: _____

Contact for Referral: _____

Phone: _____

Insurance

Health Insurance (Provide ID Number)

☐ Medicare _____

☐ Medicaid _____

☐ Other _____

_____

Qualifying Services

☐ Skilled Nursing

☐ Physical Therapy

☐ Speech Therapy

Additional Services

☐ Occupational Therapy

☐ Social Worker

☐ Home Health Aide

Specific Orders (Or attach)

☐ Instruct and Assess Medications ☐ Assess and Instruct Disease Process

☐ Lab (specify) _____

☐ Wound Care (specify) _____

_____

☐ Evaluate for _____ Therapy

☐ Other: _____

_____

Face to Face Encounter: *For all Medicare patients, a physician must have had a Face to Face visit with the patient for the reason that the patient needs home health services. This visit must occur within 90 days prior to or 30 days after the start of home health care. Please complete the information below for all Medicare Patients.*

Face to Face Visit Date: _____ **Reason** _____

Clinical Findings that Support Home Health Services *(Findings indicate skilled need, ie presence of wounds, inability to ambulate without assistance, recent surgery with pain, urinary catheter, etc.)*

_____

_____

Clinical Findings that Support Homebound Status *(Patient has great difficulty or inability to leave home unassisted or outings are infrequent ie patient becomes extremely SOB with exertion, must use a walker and assist of one person to leave home, medical restrictions due to recent surgery, dementia, etc)*

_____

_____

This form was completed by ☐ Primary Care Physician (PCP) from Face to Face Visit

☐ PCP based on information from acute/ post - acute facility physician

☐ PCP based on collaboration with Non-Physician Practitioner

Physician Signature _____ Date _____

Physician Printed Name _____

THANK YOU FOR THE OPPORTUNITY TO CARE FOR YOUR PATIENT!