VNSHS Certified Home Health Care Referral Form

Phone: 631.261.7200

Fax Referral: 631.912.1114

PATIENT INFORMATION

Last Name ____

First Name ____

Address____

City ______________________State__________Zip___________

Phone #1 ____

Phone #2 ____

Date of Birth ____________________ ❑ Male ❑ Female

Emergency Contact/Relationship _________________________

____

Day Phone ____

Evening Phone____

INSURANCE INFORMATION

Medicare #____________________________________

Medicaid # ____________________________________

Insurance Carrier Name _________________________

____

Subscriber Name _______________________________

Policy # _______________________________________

WC Y ❑ N ❑ NF Y ❑ N ❑

REASON FOR REFERRAL

- ❑ General Home Care
- ❑ Hospice
- ❑ Palliative Care Program
- ❑ Telehealth

Mandatory, attach the following:

- ❑ Last Office Note
- ❑ Current List of Medications
- ❑ History and Physical

FACE –TO-FACE ENCOUNTER CERTIFICATION

MEDICARE AND OTHER REQUIRED INSURERS ONLY

Patient Name ____

I certify that a face-to-face encounter was performed on the above named patient on _______/________/_________ by who is a

❑ Medicare enrolled physician or ❑ a permissible non-physician practitioner. The clinical reason for the encounter was:

____

____

The patient's clinical condition, as observed during the encounter, supports the patient's homebound status as follows:

____

____

FOR ALL PATIENTS

The patient's **clinical status** supports the need for the following skilled services/tasks:

- ❑ Skilled Nursing Care ____
- ❑ Physical Therapy ____
- ❑ Occupational Therapy ____
- ❑ Speech/Language Therapy ____

Certifying Physician Signature____Date ______/________/_______

Print Physician Name ________________________________Address ____

Phone ____Fax____