REQUEST FOR HOME CARE/HOSPICE SERVICE

Call (908) 895-2222 or FAX (908)722-3014

NAME: ______________________________

ADDRESS: ______________________________

____

S.S. #: _____-_____-_______

D.O.B: ____/____/______

TELEPHONE NUMBER: (_____) _____- ________

EMERGENCY CONTACT: NAME: ______________________________ PHONE: (______) _____-________

INSURANCE: Please check: ☐ MEDICARE ☐ MEDICAID ☐OTHER ________________POLICY NO.________________

REFERRING MD: ______________________________ PHONE: (______) ________-_________

PRIMARY DIAGNOSIS:

____________________ ____________________ ____________________ ____________________

PLEASE ATTACH:

- ✓ *CURRENT MEDICATION LIST(including allergies)*
- ✓ *MOST RECENT HISTORY & PHYSICAL (If available)*

Medicare Face to Face Encounter Addendum for Home Health Services

A "Face to Face" Encounter (medical visit) is required for traditional Medicare patients, the encounter must be 90 days prior to or 30 days following the start of home care services

Patient Name: ______________________ **DOB:**___/___/___ **Start of Care:** ___/___/___ **MRN #:** _______

1: Face to Face Encounter: I (or a non-physician practitioner working in collaboration with me), had a face to face encounter with this patient during which a medical condition was addressed which is the primary reason for home health care on:
Date of Encounter: ______/______/______.

2: Based on my findings, the following skilled services are medically necessary Home Health Services:

Discipline — **Reason for Skilled Service(s) (See attached examples)**

☐ Skilled Nursing for: ____

☐ Physical Therapy for: ____

☐ Speech Language Pathology for: ____

3: The following clinical findings support that this patient is homebound (See attached examples): ________________________

I, certify that this patient meets the criteria for Medicare Home Health Services. I understand I am required to have documentation in the patient's medical record to support my determination of this patient's eligibility for coverage. I will provide medical records to the home health care agency, which I understand may be used during a review and/or audit being performed by audit entities and/or CMS (Center for Medicare/Medicaid).

4: Physician's Signature with Credentials: ________________________________ **Date:** ______________

Print Signing Physician's Name: ____________________________

5: ☐ I <u>will</u> be following this patient throughout their home health care episode and understand I will be receiving this patient's Plan of Treatment for signature.

☐ I <u>will not</u> be following this patient throughout their home care episode (**Please, provide name of physician who will follow the patient and certify home care in the community**) below:

6: Community Physician Name: (please print first & last name) ________________________________

Please Fax completed form to: (908)526-6857 or (908)722-3014
For Questions Please Call: (908)895-2222