



Referral/Face-to-Face Form

**Accepting Referrals 24/7 via fax: 800-273-5331 or phone 800-462-5632
After hours (5p.m.- 7:30a.m.) may phone On-call Supervisor directly @ 313-410-6320**

Date: _____ Patient's Name: _____ Birthdate: _____
Address: _____ City: _____ Zip: _____
Phone: _____ Other Contact Name: _____ Tele. _____
Insurance: _____ Contract# _____ Group# _____
Diagnosis: _____

Services requested: RN PT OT SLP AIDE MSW Private Duty

Any special instructions: _____

Face-to-Face Attestation

I certify that this patient is under my care and that I, or a nurse practitioner/clinical nurse specialist/certified nurse-midwife or physician assistant working in collaboration with me or under my supervision, had a face-to-face visit encounter that meets the physician face-to-face encounter requirements with this patient on:

Date of Face-to-Face Visit: _____ mm/dd/yyyy

Medical Condition:

The encounter with the patient was directly related to the **following medical condition**, which is the **primary reason for home health care**:

Clinical Findings In Support of Patient's Eligibility

Provide a summary of **clinical findings that support the patient's eligibility for home health services**, including **specific need for intermittent skilled nursing and/or therapy services**. The Face-to Face visit findings must be related to the primary reason for home health admission.

Statement of Homebound Status

I certify that the patient's clinical condition, as evidenced in the face-to-face encounter, supports that this **patient is homebound** (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services OR are infrequent or of short duration when for other reasons) **due to**:

Certifying Physician Name: _____ Physician Phone: _____
Certifying Physician Signature: _____ Physician FAX: _____
Date: _____
Physician Address: _____ NPI: _____
Office Contact: _____ Phone: _____