



## 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: \_\_\_\_\_  
\_\_\_\_\_

Any special instructions:  
\_\_\_\_\_

### Face-to-Face Attestation

A face-to-face encounter that meets the CMS requirements for this patient occurred on:

DATE OF FACE-TO-FACE ENCOUNTER \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

The encounter/assessment with the patient was in whole, or in part, for the following medical conditions(s), which is the primary reason for home health care.

*List medical conditions:*

Certification of Medical Necessity:

I certify that based on my findings, the following services are medically necessary home health services. (*Check all that apply*)

Nursing

Therapy

Speech Language Pathology

Clinical Findings that support the need for home health care services:

Statement of Homebound Status:

I certify that the clinical findings support that this patient is homebound (i.e. absences from the home require considerable and taxing effort and are for medical reasons, or religious services, or infrequently or of short duration for other reason)

**because:**

Certifying Physician Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Certifying Physician Signature: \_\_\_\_\_ NPI: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Fax: \_\_\_\_\_