Metro Home Health Care

CHAP
Community Health
Accreditation Program

Referral Form

Accepting Referrals 24/7 via fax: 800-273-5331 or phone: 800-462-5632

After hours (5p.m. – 7:30 a.m.) may phone
On-call Supervisor directly @ 313-410-6320

MEDICARE CERTIFIED

Date: ________________ Patient Name: ______________________________________

Address: ____

City: ____________________ Zip: _______________

Phone: _____________________________

Other Contact Name: __________________________Telephone: ____________________

Insurance: __________________________________ Birthdate:_____________________

Contract#: ______________________________________

Group #: ___________________________

Diagnosis:____

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Services requested: ☐RN ☐ PT ☐OT ☐SLP ☐AIDE ☐MSW ☐ Private Duty

Any special instructions: ____

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Physician Name: _______________________________________NPI #:_____________________

Physician Signature: _______________________________________

Office Contact: __________________________ Phone: _________________________________

Physician Address: _______________________________________

Physician Phone: _____________________________Fax: _______________________________