Home Health Referral
Face-to-Face Encounter

Phone: (404) 633-7433
Intake Fax: (888) 633-7430
Email: intake@medside.com

Date of Visit: _____
Date of Next Visit: _____

Patient Demographics

Patient's Name: _____

DOB: _____ Sex: _____

Address: _____

City: _____

State: GA Zip Code: _____

Phone: _____

Primary Insurance: _____

Policy Number: _____

Secondary Insurance: _____

Policy Number: _____

Primary Care Physician: _____

VA Patient: Yes ☐ No ☐

The encounter with this patient was in whole or in part for the following **medical condition/diagnosis** which is the primary reason for home health care:_____

This patient is under my care. I have established a plan of care, and it will be reviewed by the physicians periodically. I have authorized the home health services. I refer to MedSide Healthcare and certify, that based on my findings, the following services are medically necessary.

My clinical findings support the need for the following Home Health services:

- ☐ Intermittent Skilled Nursing Care for _____
- ☐ Physical Therapy for _____
- ☐ Speech Therapy for _____
- ☐ Occupational Therapy for _____
- ☐ Medical Social Work for _____
- ☐ Home Health Aide for _____

Additional Instructions: _____

I certify that this patient is "confined to home" (homebound) based on meeting both of the following criteria:

Criteria 1: Homebound Reason

The aid of supportive devices such as:

- ☐ The use of special transportation
- ☐ The assistant of another person

OR

- ☐ Leaving home is medically contraindicated due to:

_____

Criteria 2:

What causes the patient the inability to leave the home **AND** why does leaving the home require a considerable and taxing effort?

_____

_____

_____

I certify that this form was completed based on a face-to-face encounter that meets the physician face-to-face requirements. The form was completed by a physician based on a face-to-face encounter or information provided by a nurse practitioner, physician's assistant, certified nurse midwife, or clinical nurse specialist working in conjunction with the certifying physician or physician who cared for this patient in an acute or post-acute facility.

Physician's Name: _____ **Physician's NPI:** _____

Physician's Signature: _____ **Date:** _____

Office Contact: _____ **Phone:** _____ **Fax:** _____