Mi Maranatha Home Health, Inc.

4307 N. 10th Street Ste. A, McAllen, TX 78504
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REFERRAL FOR HOME HEALTH SERVICES

Patient's Name: _____ Telephone#:_____ F2F Encounter Date:_____

Address (Street, City, State) _____ Zip Code: _____

D.O.B.:_____ Marital Status: _____ Race: _____ Sex: ___Female ___Male

SS #: _____Medicare#:_____ Medicaid #:_____

Private/OR other type of insurance besides Medicare/Medicaid:_____ Member ID#:_____

Emergency Contact: _____ Relationship to Patient:_____ PH #:_____

Referring Doctor: _____ Address: _____

PH #:_____ Fax #:_____ TX Lic #: _____ NPI #: _____

Principal Diagnosis: _____ Second Diagnosis: _____

Additional Diagnosis: _____
_____

I certify that based on my findings, the following services are medically necessary for this patient.
Services required: _____ SN _____ HHA _____ PT _____ OT _____ ST _____ MSW

Orders: _____

_____

_____

_____ _____

Signature of M.D./Representative Date

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Home Health Staff Name/Signature: _____ Date: _____

Type of Insurance Verification: _____ Medicare ____ Medicaid _____ Private Pay _____ Other type of insurance: _____

Transfer from Agency: _____ YES _____ NO; if YES, D/C date from Agency: _____ Verified with _____ From: _____

Admitted Date: _____ Non-Admit: Reason/Comments: _____

Home Health Face to Face Physician Communication Form

Documentation of Face to Face Encounter

Patient Name: _____ **Identification/D.O.B.** _____
In accordance with the 2015 Home Health PPS Final Rule: "It is permissible for the HHA to communicate with and provide information to the certifying physician about the patient's homebound status and need for skilled care and for the certifying physician to incorporate this information into his or her medical record for the patient."

I certify that this is under my care and that I or a nurse practitioner or physician assistant working with me – had a face to face encounter that meets the physician face to face encounter requirements.

The patient will be followed up by a physician (name) _____ who will, periodically, review the plan of care. The findings from this face to face encounter have been communicated with the patient's community-based physician who will be assuming this patient's home health plan of care.

Additional Information to Certifying Physician

Homebound Status: (<u>check off the appropriate choices</u>)

□ Exhibits considerable & taxing effort to leave home
□ Unsafe to leave home, cognitive or psychiatric impairments
□ Unable to leave home due to medical restriction (s)
□ Unable to safely leave home unassisted
□ Requires assistance to get up/move safely
□ Severe dyspnea

Principal Diagnosis: _____ **Second Diagnosis**: _____

Need for Skilled Care: _____

_____
"The certifying physician must review and sign off on anything incorporated into his or her medical record for the patient that is used to support his/her certification/re-certification of patient eligibility for the home health benefits."

Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing care, home health aide, physical therapy, occupational therapy, speech therapy, and/or social worker evaluation. The patient is under my care, and I have initiated the establishment of the plan of care.

Physician Signature: _____

Date of Signature: _____

Physician Printed Name/Credentials: _____