RELiACARE

Fax to: 989 672-2205

Your Name_____

Referral for Skilled Care and Face To Face Form

Your Phone#_____

Referral Date_____

Requested SOC Date_____

Patient Name_____

Last First M

DOB_____ SSN_____ M F

Address_____

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_____

Home Phone_____

Primary Contact_____

Phone_____

Dx_____

Medicare #_____

Other Insurance_____

Referral Notes_____

_____

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_____

Referral Information Coordinated By

_____

Physician_____

Phone_____

Face-To-Face Encounter Requirements

I certify that this patient is under my care and that I, or a nurse practitioner of Physician's Assistant working with me, had a face-to-face encounter that meets the physicians face-to-face requirements on:

_____

The encounter with the patient was in whole, or in part for the following medical condition, which is the primary reason fot the home health care *(list medical condition/orders)*:

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

□Nursing □Physical Therapy

□Occupational Therapy □Speech Therapy

□Medical Social Work □Home Health Aide

My clinical findings support the need for the above services because:

Further, I certify that my clinical findings support that this patient is homebound because:

Physician's Signature:_____ Date:_____