PrimeSTAR Home Health of NWLA

# REFERRAL FORM

**FAX TO:**
**318-532-6088**

Patient's Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Other Contact Name: _____ Phone: _____

Insurance Name: _____ Policy/Group #: _____

Referral Date: _____ Referral Contact Name/Phone: _____

## HOME HEALTH FACE-TO-FACE ENCOUNTER CERTIFICATION

1 **Encounter Date:*** _____

2 This encounter with the patient was necessitated by the following medical condition(s), which is the primary reason for home health care (List Medical Conditions);

_____

_____

**The following clinical findings support** that the **PATIENT IS HOMEBOUND** *(homebound means that there exists a normal inability to leave home, and consequently, leaving home requires considerable and taxing effort)* and that the **PATIENT NEEDs INTERMITTENT SKILLED NURSING AND/OR THERAPY:**

3 **Homebound Due To:** _____

_____

**Based on the above findings, the following are medically-necessary home health Services** (check all that apply):

4 ☐ Skilled Nursing Care For _____

☐ Physical Therapy For _____

☐ Occupational Therapy For _____

☐ Speech/Language Therapy For _____

5 _____ _____ _____

**Physician Signature** **Print Name** **Date**

Per CMS's regulation (42 C.F.R. § 424.22), "the physician responsible for performing the inital certification must document that the face to face patient encounter, which is related to the primary reason the patient requires home health services, has occurred." This document must include the "date of the encounter, an explantion of why the clinical finding of such encounter support that the patient is homebound and in need of either intermittent skilled nursing or therapy services as defined in § 409.42 (a) and (c)."

*Encounter date must be which 90 days prior to start of home health care or within 30 days after the start of care.

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