HOME CARE REFERRAL FORM

3512 Quentin Road • Brooklyn, NY 11234
Phone: (718) 475 - 4735 • Fax: (718) 838-1389
www.QualityNY.com • Email: Referrals@QualityNY.com

PATIENT INFORMATION

LAST NAME:		FIRST NAME:		
ADDRESS:		CITY:	STATE:	ZIP:
PHONE:	CELL:	LANGUAGE SPOKEN:		
DATE OF BIRTH: / /	❑ MALE ❑ FEMALE	SOCIAL SECURITY NUMBER:		
EMERGENCY CONTACT:		RELATIONSHIP:		
DAYTIME PHONE:		EVENING PHONE:		

INSURANCE INFORMATION

MEDICARE NUMBER:	MEDICAID NUMBER:
INSURANCE CARRIER NAME:	MANAGED CARE: ❑ YES ❑ NO
INSURANCE POLICY INFORMATION:	

REFERRING PARTY

FROM (FACILITY/ORG.):		CONTACT:
PHONE:	FAX:	E-MAIL:
IS THIS PERSON INTERESTED IN CDPAS? ❑ YES ❑ NO		

REFERRING PHYSICIAN

PHYSICIAN NAME:		ADDRESS:	
PHONE:	FAX:	NPI:	LICENSE:
HOME CARE DIAGNOSIS:			
PATIENT'S MEDICATION:			
❑ HHA RECOMMENDED			

FACE-TO-FACE ENCOUNTER CERTIFICATION

MEDICARE AND OTHER REQUIRED INSURERS ONLY:

PATIENT NAME:

I CERTIFY THAT A FACE-TO-FACE ENCOUNTER WAS PERFORMED ON THE ABOVE NAME PATIENT ON / / BY:

WHO IS A ❑ MEDICARE ENROLLED PHYSICIAN OR ❑ A PERMISSIBLE NON-PHYSICIAN PRACTITIONER, THE CLINICAL REASON FOR THE ENCOUNTER :

ALL PATIENTS:

THE PATIENT'S CLINICAL CONDITION, AS OBSERVED DURING THE ENCOUNTER, SUPPORTS THE PATIENT'S HOMEBOUND STATUS AS FOLLOWS (BRIEF NARRATIVE):

THE PATIENT'S CLINICAL STATUS SUPPORTS THE NEED FOR THE FOLLOWING SKILLED SERVICES/TASK

❑ SKILLED NURSING CARE ❑ OCCUPATIONAL THERAPY ❑ OTHER: ______________________

❑ PHYSICAL THERAPY ❑ SPEECH/LANGUAGE THERAPY

CERTIFYING PHYSICIAN SIGNATURE:	DATE: / /
PRINT PHYSICIAN NAME:	ADDRESS:
PHONE:	FAX:

THANK YOU FOR CHOOSING QUALITY HEALTHCARE!

QUALITY HEALTHCARE INTAKE SPECIALIST:	PHONE: