AVOCARE REFERRAL FORM

Phone Referral and Inquiries: **1-810-275-1885** Fax Referral: **1-810-391-2263**

PATIENT AND INSURANCE INFORMATION

PATIENT INFORMATION

Last Name _____

First Name _____

Date of Birth _____/_____/_____ ○ Male ○ Female

Patient Address _____

Apt #____City _____ State_____ Zip _____

Cell Phone _____

Other Phone _____

Email _____

Language Spoken_____

Emergency Contact/Relationship_____

Contact Primary Phone _____

Was the patient discharged in the past 14 days? ○ Yes ○ No

If so, facility name_____

DATE OF DISCHARGE _____/_____/_____

Was this stay Inpatient? ○ Yes ○ No? ED Visit ○ Yes ○ No?

Observation Stay ○ Yes ○ No?

REFERRAL SOURCE Name _____

Address _____

Phone _____

PATIENT INSURANCE INFORMATION

Medicare No. _____

Medicaid No. _____

Insurance Carrier (Name and Authorization No.)

_____

Subscriber Name _____

Policy No. _____

Group No. _____

Secondary Insurance Information

Insurance Carrier (Name and Authorization No.)

_____

Subscriber Name _____

Policy No. _____

Group No. _____

REQUESTED START OF CARE DATE: _____/_____/_____

FACE-TO-FACE CERTIFICATION

☐ **FOR HOME HEALTH SERVICE UNDER MEDICARE:**

I am a Medicare PECOS enrolled physician, nurse practitioner, or physician's assistant and I certify that: This patient is confined to the home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, and additionally may need occupational therapy. The patient is under my care. A plan of care has been established and will be reviewed periodically by a physician. A face-to-face encounter occurred no more than 90 days prior or 30 days after the start of home health and was related to the primary reason the patient requires home health services; the encounter was performed by a physician or allowed non-physician practitioner on

☐ **FOR HOME HEALTH SERVICE UNDER MEDICAID:**

I am a Medicaid OPRA enrolled physician, nurse practitioner, or physician's assistant and I certify that: This patient needs nursing care, physical therapy and/or speech therapy and additionally may need occupational therapy that is medically necessary.This patient is under my care. A plan of care has been established and will be reviewed periodically by a physician. A face-to face encounter occurred no more than 90 days prior or 30 days after the start of home health and was related to the primary reason the patient requires home health services; the encounter was performed by a physician or allowed non-physician practitioner on

_____/_____/_____ **ENCOUNTER DATE**

HOME CARE DIAGNOSIS

DIAGNOSES (Please attach Medical history)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

HOME CARE ORDERS

SKILLED NURSING SERVICES

☐ Observation/Assessment/Education (Specify plan)

_____

☐ Medication Management _____

☐ Disease Management _____

☐ Wound Care _____

☐ Injections _____

☐ IV Therapy (Medicare) _____

☐ Behavioral Health (Medicare) _____

☐ Other Skilled Nursing Service _____

THERAPY SERVICES

☐ Physical Therapy _____

☐ Occupational Therapy _____

☐ Speech Language Pathology_____

ADDITIONAL SERVICES

☐ Identifying as LGBTQ+ _____

☐ Identifying as GAP (Gender Affirmation Program)

_____

☐ Other _____

PROVIDER

Print Provider Name_____ Provider Signature_____ Date ___ /___ / ___

Provider Address _____ Phone _____ Fax _____

Office Contact Name_____ E mail_____ Phone _____