



APEX

Home Health Care, Inc

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FACE-TO-FACE ENCOUNTER INTAKE / REFERRAL FORM

Patient Name: _____ Date of Birth _____ Gender: _____ MR _____

Patient Address: _____ City/State/Zip: _____ Tel. # _____

Emergency Contact: _____ Relationship _____ Contact # -> _____

Medicare No.: _____ Part A _____ Part B _____ Medicaid/Insurance No.: _____

Hospital/SNF/Rehab Info _____ Inpatient Stay Date: From: _____ To: _____ Allergies: _____

Physician Name: _____ NPI/License #: _____ Tel # _____

Physician Address _____ City/State/Zip: _____ Fax # _____

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

_____/_____/_____.
MONTH / DAY / YEAR

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care (MEDICAL CONDITION(S)/DIAGNOSIS):

DIAGNOSIS:	DIAGNOSIS CONTINUED:

I certify that, based on my finding, the following services are medically necessary home health services:

- NURSING PHYSICAL THERAPY SPEECH LANGUAGE PATHOLOGY
 CHHA OCCUPATOINAL THERAPY SOCIAL WORKER

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

Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons, religious services OR are infrequent or of short duration when for other reasons) due to:

Physician Signature _____ **Date** ____/____/____

Referral Accepted by: (Print Name/Title) _____ Sign _____ Date ____/____/____