Sincerity Health

Caring for you like one of our own

Jaime RN,WCC
(956) 455-6457

Phone: (956) 350-9707 **FAX: (956) 350-0667**

REFERRAL FORM

PATIENT'S INFORMATION		
PATIENT'S NAME:		SEX ☐ M ☐ F
ADDRESS:	CITY:	
Home Phone:	SSN:	DOB:
Cell Phone:	Alternate Contact Name/ #:	
Medicare #	Private Insurance Name:	
Medicaid (HMO name):	Insurance #	
Medicaid #:	Group/policy#:	

Face to Face Encounter (Required)

The encounter with the Patient was in whole, or in part, for the following medical condition, which is the primary reason Home Health Care(List Medical condition, reason for Face to Face encounter) : _____

_____

_____

I certify my clinical findings support that this Patient is homebound per CMS guidelines due to :_____

_____

_____

Face to Face encounter date:_____
Month Day Year

Clinical findings/Diagnosis: _____

Services Medically Necessary: SN_____ PT_____ OT_____ ST _____ HHA _____ MSW _____ Dietitian_____

Orders/Frequency: _____

_____

Medical History: _____

Physician Name:_____

Physician Signature:_____ **Date**:_____

Content of form base on CMS Calendar Year 2011 Final Rule Face to Face Encounter Requirements