NOLIMITS NYC HOME CARE

REFERRAL FORM

Referral Source _____

_____

Contact Person _____

Phone # _____

Notes _____

PROVIDER'S NAME , ADDRESS AND TELEPHONE #	REFERRING DOCTOR	
Name: Nolimits NYC Home Care Corp.	Physician Name:	
Address: 2753 Coney Island Ave 1st Floor Brooklyn, NY 11235	Address:	
Phone: 718 616 8690	NPI:	License Number:
Fax: 917 830 6387	Telephone:	Fax:

PATIENT INFORMATION			
First And Last Name:		Sex: ☐ Female ☐ Male	Tel:
Address	City	State	Zip Code
Social Security	Lives With ☐ Family ☐ Alone ☐ Caregiver	DOB	Language Spoken
Family Contratc / Relationship(Must Provide For PRI)		Telephone	Cell

Brief Narrative System: State physical findings from face to face encounter that indicate reason patient is homebound and requires intermittent skilled nursing services and / or therapy services. this document is an addedum to the initial certification as required by the Centres for Medicare and Medicaid Services.

INSURANCE

Medicare:
Medicaid:
Other:

FACE TO FACE ENCOUNTER

I certify that this patient is under my care and that I had a face-to-face encounter that meets the Medicare face-to-face encounter requirements with this patient on **(insert date that visit occured)** : _____

Face to Face Eencounter related to primary reason for homecare?

☐ YES ☐ NO

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(list medical condition): _____

I certify that, based on my findings, the following services are medically necessary home health services: (check all that apply):

☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ HHA

To provide the following care/treatments (required only when the physician completing the face-to-face encounter documentation is different than the physician completing the plan of care): _____

_____

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

_____

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

_____

_____

_____

Attending Physician 'S Signature And Date:

_____

Date Provider Received Signed Document:

_____