WayPoint
HOME HEALTH CARE

Referral for Home Health Services

Patient Name: _____ DOB: _____

Address: _____

Phone: _____ SS # _____

Primary Insurance: ▫MCR ▫Other: _____ Ins or MCR #_____

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: **(insert date that visit occurred):** _____

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. List medical condition(s): _____

_____

I certify that based on my findings the following services are medically necessary home health services

▫Nursing ▫Physical therapy ▫Occupational Therapy ▫Speech Therapy ▫MSW

To provide the following care/treatments: _____

_____

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 or religious services or infrequently or of short duration when for other reasons) because: _____

_____

_____

Physician Printed Name_____

Physician Signature _____Date of Signature_____

Fax to: (844) 659-2825

Thank you for allowing us the opportunity to care for your patient!

WayPoint Home Health

2140 S. Riverside Dr., Ste 24, Edgewater, FL 32796
Ph: (386) 410-5600 License# 299994449

500 N. Washington Ave. Suite 108. Titusville, FL. 32796
Ph: (321) 267-2950 License# 299943831