



Fax Referral Sheet  
Physician's Choice Homecare

*"Quality Is Our # 1 Priority"*

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www.physicianschoicehomecare.com

Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Physician NPI: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

SSN#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Medicare #: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

Ins Provider: \_\_\_\_\_

Policy #: \_\_\_\_\_

I certify that, based on my findings, the following services are medically necessary home health services (Check all that apply)  
**(Required only when the physician completing the face to face encounter documentation is different than the physician completing the plan of care):**

Skilled Nursing

Occupational Therapy

Home Health Aide

Physical Therapy

Speech Therapy

Other: \_\_\_\_\_

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) (MM/DD/YYYY): \_\_\_\_\_

The patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care or will be transferred to the care of his/her physician and I have authorized home health services.

Referring Physician/Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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