Face –to-Face/Referral Form

PLEASE FAX TO: 248-242-4721
TEL: 248-242-4720 www.athhs.com

8898 Commerce Rd. Ste. 2B
Commerce Twsp. MI 48382

For Physician Office use: I certify that this patient is under my care and I, or a nurse practitioner or physician's assistance working with me, had a face to face encounter that meets the physician face to face encounter requirements with this patient on Date: ________

Patient: ____
Last First Mi

Address: ____ MI. ____________
Street City State Zip

Phone ____________________ M ☐ F ☐ DOB: _________

Primary Insurance and Number: ____

Emergency Contact/Relationship: ____

The encounter with the patient was in whole, or 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:

- ☐ Skilled Nursing
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Home Health Aide
- ☐ Medical Social Worker
- ☐ Dietitian: ________________

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

Physician Name: ______________________________________ Phone Number ____________ Fax ______________

Physician Signature: ________________________ MD/DO ______ **Date:** _________ NPI: ____________________

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