CenterWell Home Health

CenterWell Home Health Contact Center
Phone **833-453-1099** | Fax **833-453-1106**
Website_ProviderReferral@CenterWellHomeHealth.com

Home Health Referral

Referral date: _____

We will see your patient within 48 hours unless a specific start of care date is provided here: _____

Patient name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ DOB: _____ ☐ Male ☐ Female

Alternate contact: _____ Contact #: _____ Relationship: _____

Payer: ☐ Medicare ☐ Insurance (insurance contact #): _____

Medicaid ☐ Yes ☐ No Other: _____

HIC/ID#: _____ Policy #: _____ Group #: _____

Referring Primary Care Provider: _____ Phone: _____

Referring facility: _____

Primary Care Provider for home health orders: _____ Phone: _____

Diagnoses: _____

Face-To-Face Encounter

Visit within past 90 days: ☐ **Yes** ☐ **No** **Face-To-Face Encounter date:** _____

Please send the completed referral form and attach a copy of the Primary Care Provider's most recent signed and dated encounter with this patient which supports the reason for the ordered Home Health services. Examples may include: Primary Care Provider progress note, history and physical, discharge summary.

Orders

Skilled Nursing for: ☐ Medication management and teaching ☐ Disease management and teaching

☐ Observation and assessment of: _____

☐ Wound care (specify below or attach orders): Location: _____ Frequency: _____

Clean w/: _____ Dress w/: _____

Pack w/: _____ Cover w/: _____

Infusion (attach orders) ☐ Yes ☐ No ☐ Other (specify): _____

Physical Therapy for: ☐ Evaluation and treatment ☐ Other (specify): _____

Occupational Therapy for: ☐ Evaluation and treatment ☐ Other (specify): _____

Speech Therapy for: ☐ Evaluation and treatment ☐ Other (specify): _____

Home Health Aide for: ☐ Personal care/assist with ADLs

Medical Social Worker for: ☐ Community resources ☐ Long-term planning ☐ Other (specify) _____

Specialty Programs

☐ **Cardiopulmonary/Keeping Hearts at Home**	☐ **MyNICaS™**	☐ **Sepsis**
☐ **Daily Difference with Diabetes**	☐ **Orthopedic**	☐ **Zontago®**
☐ **DEMA Grant**	☐ **PRIME Wound Care™**	
☐ **Low Vision**	☐ **Safe Strides®**	

Print Primary Care Provider's name: _____

Primary Care Provider's signature: _____ **Date:** _____

Home health services are available for all eligible patients with a healthcare provider referral.

CenterWell™ does not discriminate on the basis of race, color, national origin, age, disability or sex. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-2188 (TTY: 711). 注意：如果您使用繁體中文，您 可以免費獲得語言援助服務。請致電 1-877-320-2188 (TTY: 711).

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