



Phone: 800.644.2558

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"Your Peace of Mind Delivered!" Fax: 877-365-1937

Referral Intake Form

Patient's Name: (Last Name) , (First Name) , (M.I.)
Address: City / State: Zip Code:
Telephone #: () D.O.B. / / *known Latex Allergy Yes No
SS#: Medicare#: Secondary Insurance:
Authorization#: Date of Order: / / Ordered By:
Is this patient currently being seen by Home Health? Yes No

This Order Represents 30 Day Supply, Unless Otherwise Stated.

Table with columns: Wound Care, Type or ICD.9 Code, Location, Length, Size OM, Depth, Drainage, Thickness, Debridement or Surgery Date. Includes rows for Promogran, Prisma, Silvercel, Allevyn, Duoderm, Adaptic, Kerlix Roll, ABD Pad, Paper Tape, and Other.

Table with columns: Wound Care, Type or ICD.9 Code, Location, Length, Width, Depth, Drainage, Thickness, Debridement or Surgery Date. Includes rows for Promogran, Prisma, Silvercel, Allevyn, Duoderm, Adaptic, Kerlix Roll, ABD Pad, Paper Tape, and Other.

Notes

Physician's Name:
Address:
City: State: Zip Code:
Telephone * () Fax # () -
NPI#

Physician's Signature

Assignment of Benefits: I request that payment of insurance benefits be made on my behalf to HOMELINE, INC./ LIFE CARE DELIVERED. and/or any of its corporate affiliates for any medical supplies and/or medications furnished to me by HOMELINE, INC./ LIFE CARE DELIVERED. I authorize any holder of medical information about me to release to HOMELINE, INC./ LIFE CARE DELIVERED, my physicians, caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

If another service provider is identified who can process this claim. I authorize HOMELINE, INC./LIFE CARE DELIVERED to forward my medical records and advise the medical professionals in my care.
Patient Signature: Date:

If the patient is being treated by Home Health at the time of this service, the patient will be responsible for aft charges not covered by thier insurances per Assignment of Benefits.