HealthPlan OF SAN MATEO

801 Gateway Blvd., Suite 100 | South San Francisco, CA 94080

www.hpsm.org

Home Health Physician Order Form

Physician's Name

Home Health Agency

Patient's Name

Patient's Date of Birth

I certify that the above patient is under my care and that I, the physician or a nurse practitioner/physician's assistant working with me had a face-to face encounter with this patient on: ______________ (date of last visit)

CLINICAL JUSTIFICATION (Required)

Brief narrative of the clinical conditions to support the need for skilled Home Health Care:

HOMEBOUND PATIENT

Please Explain the reason(s) the patient is confined to home: (examples: medical orders, recent falls, wheel chair bound, shortness of breath requiring frequent rest periods, cognitive issues, difficulty walking)

Physician's Signature

Date Signed

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Retrospective Home Health Services Request Form

Physician's Name

Home Health Agency

Date of the Physician Order

Date Prior Authorization Form faxed to HPSM

PREVIOUS HOME HEALTH VISITS

▸ In the period from: to:

Patient has been visited by Skilled Nurse, P.T., O.T., S.W., S.T., H.H.A.

▸ In the period from: to:

Patient has been visited by Skilled Nurse, P.T., O.T., S.W., S.T., H.H.A.

▸ In the period from: to:

Patient has been visited by Skilled Nurse, P.T., O.T., S.W., S.T., H.H.A.

Brief Narrative Regarding Reason to Provide Retrospective Visits:

Brief Narrative Regarding Care Provided:

Brief Narrative Regarding Clinical Goals: