Menorah Park Home Health Services | 27100 Cedar Rd., Beachwood, OH 44122 • 216-595-7333 / Fax: 216-595-7329
Summit & Canton Home Health Services | 405 Tallmadge Road, Suite 201, Cuyahoga Falls, OH 44221
Summit: 330-867-2143 / Fax: 330-867-2350 | **Canton**: 330-437-2910 / Fax: 330-437-2911

Visit us at: MenorahPark.org

Home Health Referral / Telehealth Assistance Request

Demographics (*may be attached*):

Patient's Name:____________________ DOB:__________ Sex:______ SSN:______________

Address:________________________ City:______________ State: OH Zip: __________

Phone/s: ____

Primary Care Physician: __________________________________

Primary Insurance:________________________ Policy #:____________________

Secondary Insurance:________________________ Policy #:____________________

The encounter with this patient on (date): __________________(attach a signed copy of the encounter) was in whole or in part for the following medical condition/diagnosis which is the primary reason for home health care: ____________________
This patient is under my care. I have established a plan of care, and it will be reviewed by a physician periodically. I have authorized the home health services. I refer to Menorah Park Home Health and certify, that based on my findings, the following services are medically necessary.

My clinical findings support the need for the following Home Health services:

☐ Intermittent Skilled Nursing Care for______________________________

☐ Physical Therapy for______________________________

☐ Speech Therapy for______________________________

☐ Continues to need Occupational Therapy for______________________________

☐ Medical Social Work for______________________________

☐ Home Health Aide for______________________________

Additional Instructions: ☐ **Assist my patient with a Telehealth visit from me on** ________ (Date) **at** ________ (Time).

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I certify that this form was completed based on a face-to-face encounter that meets the physician face-to-face encounter requirements. The form was completed by a physician based on a face-to-face encounter or information provided by a nurse practitioner, physician's assistant, certified nurse midwife, or clinical nurse specialist working in conjunction with the certifying physician or physician who cared for this patient in an acute or post-acute facility.

Physician's Name:____________________________ NPI:__________________

Physician's Signature:____________________________ Date:__________________

Office Contact: ____________Phone Number:______________ Fax Number:______________