



Phone: 800.644.2558

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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 5 columns: Wound # 1, Type or ICD.9 Code, Location, Size (Length, Width, Depth), Drainage (D, L, M, H, R, I, O, E, Y, G, D, A, H, V, T, Y), Thickness (Part, Full), and Debridement (or Surgery Date). Includes rows for Promogran, Prisma, Silvercel, Allevyn, Duoderm, Adaptic, Kerlix Roll, ABD Pad, Paper Tape, and Other.

Table with 5 columns: Wound # 2, Type or ICD.9 Code, Location, Size (Length, Width, Depth), Drainage (D, L, M, H, R, I, O, E, Y, G, D, A, H, V, T, Y), Thickness (Part, Full), and 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 physician(s), 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 all charges not covered by their insurances per Assignment of Benefits.