SUMMIT
ORTHOPAEDIC HOME CARE

PATIENT NOTIFICATION OF FACE TO FACE HOME CARE REQUIREMENT

Patient Name: Patient ID Number:

I,_____ (Patient Name) have received notification that my insurance provider requires face to face visit with my physician (whom agrees that I need home care services) and that I have had that visit either 90 days prior to the start of home care services or 30 days after home care services have begun.

I understand that I am responsible to meet this requirement in order for my home care services to continue uninterrupted and I understand that if this visit is not conducted, my homecare services may be put on hold and/or I may be discharged from care. _____ (Initials).

I also understand that my insurance company may not pay for any visits that have occurred during the time period that this requirement is not met_____ (Initials).

Patient Signature: _____ Date: ___/___/___

Print Name: _____

Clinician Signature: _____ Date: ___/___/___

Print Name: _____