SUMMIT
HOME CARE

HOME CARE ORDER

Please **FAX** this to script to your account manager or to the office below with demographics, history, and physical or latest visit note.

Patient Information

Patient Name:

Date of birth: ____ / ____ / _____

SSN:

Diagnosis:

ICD10 Code(s):

Services Requested

- ☐ Skilled Nursing
- ☐ PT Evaluation & Treatment
- ☐ PT/INR Check
- ☐ OT Evaluation & Treatment
- ☐ Speech Evaluation & Treatment
- ☐ Home Health Aide
- ☐ Medical Social Worker
- ☐ Catheter Change
- ☐ DME- Item(s) Needed_____

_____

Height: _____ Weight: _____

LON: _____

Visits & frequency (if specified) or additional orders: _____

_____

_____

_____

Surgery Date:

Hospital:

Physician Signature:

Printed Name:

Physician NPI#

Date:

My signature above certifies that home health care services are medically necessary.

Columbus Fax: 614-866-8160 Cincinnati Fax: 513-322-4757 Indiana Fax: 317-245-7280

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