Trust USA
Home Health, LLC

TRUST USA HOME HEALTH PATIENT REFERRAL

MR# _____ Referral Date: _____ S.O.C. _____

Admission Status: New Admission: _____ Re-admit _____

Patient's Name: _____
(Last Name) (First Name) (M)

Address: _____ Apt. # _____ City:_____

Zip: _____ Phone: _____ Cell: _____ Other:_____

D.O.B. _____ SS# _____M.C.#: _____

Emergency Contact: _____ Relation to Pt. _____

Phone #: _____

Case Referred By: _____ Title: _____

Hospital/Institution _____ Admit Date: _____ D/C: _____

Principal Dx: _____ Secondary Dx: _____

Other Dx: _____

New Meds: _____

MD Verbal Orders: _____

Referring MD: _____ Phone # _____

Address: _____ Zip: _____ NPI #: _____

Admission Nurse: _____ Aide: _____

F/U SN: _____ PT/OT/ST: _____

MSW: _____

Frequency: _____

Signature: _____ Name/Title: _____ Date: _____

PAYER INFORMATION

Medicare No: _____ Medicaid No: _____

Commercial Insurance Co: _____ Phone: _____

Insurance ID: _____ Insurance Group #: _____

Questions to ask the Commercial Insurance Carrier

What is the Deductible: _____ Has it Been met: _____

# of Visits allowed: _____ Out of Network%: _____ Bill type: _____

Maximum Home Health Benefits: _____ Out of pocket: _____

Pre-Authorization #: _____

REFERENCE # 2003 HOME HEALTH