MEDICAID PHYSICIAN'S WRITTEN PRESCRIPTION FOR HOME HEALTH SERVICES

GENERAL INFORMATION

1. **TODAY'S DATE:** _ _ / _ _ / _ _ _ _

2. **Certification Request:** (check one)
   Initial Re-certification

(Re-certification required at least every 60 days for home health visits and at least every 180 days for private duty nursing and personal care services.)

3. Date of last physician's office visit: _ _ / _ _ / _ _ _ _

PATIENT INFORMATION

4. Medicaid ID Number (10 digits) _ _ _ _ _ _ _

5. MediPass Authorization # (if applicable): _ _ _ _ _ _ _ - _ _

6. Last Name: _____ First Name: _____

7. Gender: Male Female

8. Date of Birth: _ _ / _ _ / _ _ _ _

9. Phone #(_ _ _) _ _ _ - _ _ _ _

10. Street Address: _____

City: _____ State: _____ Zip Code: _____

PATIENT MEDICAL AND SOCIAL INFORMATION

11. Diagnosis(es):

ICD-9 Code(s) *(Provided by a Physician):*	Written Description:	Date of Diagnosis:
_ _ _ . _ _		__/__/____
_ _ _ . _ _		__/__/____
_ _ _ . _ _		__/__/____

12. Home Health Services ordered:

13. Frequency and duration:

14. Reason services must be provided (must be medically necessary):

15. Skill level required (i.e. RN, LPN, or Aide): _____

ORDERING PHYSICIAN INFORMATION

16. Name: _____

17. Phone # (_____) _____ - _____

18. Street Address: _____

City: _____ State:___ Zip Code: _____

19. Provider Medicaid ID Number: _ _ _ _ _ _ _ - _ _
OR
Provider NPI Number: _ _ _ _ _ _ _ _ _ _
OR
Provider Medical License Number: _ _ _ _ _ _ _

PHYSICIAN'S SIGNATURE: ***I certify that home health services are medically necessary for this individual, as furnished in this written prescription for services. This individual is under my care and I have examined him within 30 days prior to the initiation of services or within the last 6 months for continuation of services.***

Signature: _____ ***Date:*** __/__/____

AHCA-Med Serv Form 5000-3525, Revised February 2013 (incorporated by reference in Rule 59G-4.130, F.A.C.)