Consumer Sensitive (Confidential)

A logo with a person in a house

AI-generated content may be incorrect.

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**Fusion Hospice Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **Insurance Type:** | | | **Insurance ID:** |
| **Patient Name:** | | | **Physician Ordering Hospice: Dr:** |
|  | | | **Address:** |
| **Date of Birth:** | **SSN** | **Sex:** |  |
|  |  |  | **Ph:** |
| **Phone:** | | |
| **Responsible Party:** | | | **Fax:** |
| **Patient Address:** | | | **Primary Problem for Hospice Care:**  **Additional Diagnosis:** |
|  | | |
| **EVENT PROMPTING REFERRAL** | | | **PLAN OVERSIGHT** |
| * Hospital/Facility stay from to for Primary problem noted above. Hospital/SNF Physician or NPP\* may complete the attestation of face to face encounter within 90 days prior to Start of Care date for Hospice Services. * Face to Face encounter on Re: Primary problem for Hospice, Encounter must be within 90 days prior to Start of Care date for Hospice Health Services. * No Face to Face encounter for the primary problem note above has occurred within the past 90 days.   **MUST COMPLETE BELOW.** | | | **Will the ordering physician sign and oversee the plan of care:**   * **Yes □ No**   **If No,** which physician is to sign and oversee the Plan of Care? Dr. :  **---------------------------SERVICES ORDERED-------------------------------**  The following services are medically necessary:  **--------------ATTESTATION OF FACE to FACE ENCOUNTER------------------** |
| **----------------CMS REQUIREMENTS IF NO FACE TO FACE----------------** | | | **My clinical findings support the need for Hospice services as follows:** |
| **Encounter Due Date:** Must be within 30 days of SOC – see order date in “services ordered” area  **Physician who will perform (or have NPP\* perform) the Face to Face encounter & oversee the Plan of Care:** | | |  |
| **Dr:** | | |  |
| **I certify my clinical findings support that this patient is Hospice bound per CMS guidelines due to:**  **(Include physical conditions, mental impairments, physician-ordered restrictions)** | | | |
| **I certify that this patient is under my care and that I had a face to face encounter that meets the Physician Face to Face requirements with this patient as noted above.** | | | |
| **Signature of Physician or NPP who performed Face to Face encounter and informed Certifying Physician:**  **X Date:** | | | |

Content of form based on CMS Calendar Year 2023

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