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.)