



MID-MICHIGAN HOME HEALTH CARE, INC.

REQUEST FOR HOME HEALTH CARE SERVICES

1. CLIENT INFORMATION				S.O.C.:	
Name (Last, First, Middle)				Clinical Record No.	
Address (Street and No.)		City		State	Zip Code
Telephone No. ()	Birth Date	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Religion		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced
National Origin <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Oriental <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Other (Please describe) _____					

Principal Diagnosis/ Date	Principal Diagnosis ICD - 9 CM -Code
Secondary Diagnosis/ Date	Secondary Diagnosis ICD - 9 CM -Code

Treatments, Medications, Diet, Activity permitted

Physician Signature: _____		UPIN #: _____	
Name of Attending Physician (Last, First, Middle)		UPIN #	
Address of Attending Physician (Street and No.)		Telephone No / Fax No. ()	
City		State	Zip Code

Payment Source: <input type="checkbox"/> Private <input type="checkbox"/> Ins. Co. <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Auto Ins. <input type="checkbox"/> Other _____					
Insurance Contract No.		Insurance Group No.		Insurance Individual No.	
Social Security No.		Medicare No.		Medical Assistance No.	
Name of Insurance Co.			Type of Insurance Coverage		
Address of Insurance Co. (Street and No.)		City		State	Zip Code
Name of Policyholder (Last, First, Middle)					

Signature of Individual Completing Form	Date	Name of Nurse Supervisor
---	------	--------------------------