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www.advancecarellc.com

JCAHO Accredited
Medicare/Medicaid Certified
Licensed, Bonded & Insured

Home Health Orders

Patient's Name:____ DOB: __________

PLEASE FORWARD A COPY OF THE PATIENT'S DEMOGRAPHICS

Primary Insurance Type	**ID #**
❑ Medicare	________________________
❑ Medicaid	________________________
❑ Medicare Advantage Plans	________________________
❑ Tricare	________________________
❑ Blue Cross Blue Shield	________________________
❑ Gentiva Carecentrix/Cigna	________________________
❑ Other	________________________

*Skilled Nursing Orders:*____

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- ❑ Physical Therapy ________________________
- ❑ Occupational Therapy ________________________
- ❑ Speech Therapy ________________________
- ❑ Medical Social Worker ________________________
- ❑ Home Health Aide ________________________

Comments: ____

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Physician's Signature: ________________________________ Date: __________