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 ❑ Female ❑ Male	Religion	Marital Status ❑ Single ❑ Widowed ❑ Married ❑ Divorced
National Origin ❑ White ❑ African American ❑ Oriental ❑ Hispanic ❑ American Indian ❑ 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 #:	Telephone No./ Fax No. ( )	
Address of Attending Physician (Street and No.)	City	State	Zip Code

Payment Source: ❑ Private ❑ Ins. Co. ❑ Medicare ❑ Medicaid ❑ Worker's Comp. ❑ Auto Ins. ❑ 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