HUMANISTIC HOME CARE
Provider Request Form

Email completed forms to:
QBROWN@HUMANISTICCARE.COM
Phone: (248) 747-1396

Humanistic Home Care helps patients remain independent at home by providing support with activities of daily living.

To refer a patient to receive personal care services to assist with activities of daily living, please provide the information requested below.

Insurance member ID:	**Member name:**	**Date of birth:**	**Member phone:**
Physician Name:	**Physician Address:**	**NPI #:**	
Physician FAX number:	**Physician phone number:**	**Preferred Provider for Personal Care Services:** Humanistic Home Care	

Patient care needs

Chronic or Behavioral Health Conditions	
Please list any chronic conditions/illnesses or behavioral health conditions:	Diagnosis Code(s):

Home Care Services Required			
Please select all types of services that apply			
☐	Bathing	☐	Transferring
☐	Dressing	☐	Housework
☐	Eating	☐	Laundry
☐	Grooming	☐	Medication
☐	Mobility	☐	Meal Preparation
☐	Toileting	☐	Shopping

Frequency of Services	
Please select all that apply	
☐	24 hours (Live-in support)
☐	2-3 hours per day
☐	4-8 hours per day
☐	12 hours per day
☐	Other, please explain:

Duration of Services	
Please select all that apply	
☐	Long Term Care support.
☐	Other, please explain:

Reason for Home Care Services
Please list any cognitive of physical limitations:

Physician Certification: I, the undersigned, certify that the above-named patient requires home care services as outlined above due to their medical condition.

Physician Signature: ____

Date: ______________________

Consent to Share Information: I, the undersigned patient, authorize my physician to release relevant medical information to Humanistic Home Care and my insurance provider for the purpose of verifying the necessity of home care services.

Patient Signature: ____

Date: ______________________