HMS2

Referral for Home Medical Services and Palliative Care Benefit

This form is for use by the referring physician in order for a patient to receive medical services in the home setting in accordance with section 3(xv) and 3(xliv) of the Health Insurance (Standard Health Benefit) Regulations 1971.

PART A – PATIENT INFORMATION

Last name:	First name:	Middle Initial(s):	Unique Patient Identifier (UPI):

Date of Birth:	Sex: ☐ Male ☐ Female	Tel. No.:

Full Physical Address:

Insurance Company:	Policy No.:	Cert. No.:

Patient is being referred from: ☐ Hospital/Hospice ☐ Community	ICD-9 code(s):	Onset of symptoms date:

PART B – REFERRAL

Referring physician:	Physician contact No.:

Name of Approved Home Medical Services Agency to which patient is being referred:

Medical procedure(s) for which patient is being referred (**Check all that apply**):

GENERAL SERVICES

☐ 99341	Home visit initial
☐ 93792	INR monitoring services
☐ 99503	Respiratory therapy care
☐ 99504	Mechanical ventilation care
☐ 99505	Stoma care & maintenance
☐ 99506	Intramuscular injection
☐ 99507	Catheter care & maintenance
☐ 99511	Enema administration
☐ S9097	Wound care
☐ 97602	Wound care non-selective
☐ G0299	Skilled nursing services (including central line care)
☐ G0493	Skilled nursing services (observation and assessment)
☐ G0495	Skilled nursing services (patient education)

HOME INFUSION

☐ 99601	Infusion (initial 2 hrs)
☐ 99602	Infusion (each additional hr)

OTHER HOME SERVICES

☐ E0779 MOD RR	IV pump, 8+hours (modifier rental)
☐ 36415	Routine venepuncture
☐ 99001	Specimen handling
☐ 80299	Quantitative assay drug
☐ 96523	Flush vascular device

PALLIATIVE CARE (TLC and PALS only)

☐ G0180/79	End-of-life certification/recertification
☐ G0182	Palliative End-of-life Care

This benefit requires that the above named patient be certified (G0180 by an approved physician before they can be referred for palliative end-of-life care.

HOME SUPPORT SERVICES

☐ 97802	Initial evaluation for medical nutrition	☐ 97803	Medical Nutrition follow-up	☐ 97804	Group medical nutrition visit

Additional instructions and treatment details - *Please include the type, frequency and/or continuation of service and any medication(s) required. Use additional sheet if necessary.*

Please fax IV prescriptions (excl TPN) to Avant Pharmacy at 236-7250 and all other prescriptions to BHB Pharmacy at 239-2074 or 239-2129

PART C - DECLARATION OF REFERRING PHYSICIAN

I understand that if this referral is accepted, the insurance company will require documentation of medical necessity. I authorize release of the above named medication to the approved HMS agency that I am referring the patient to.

Physician signature _____ Date _____

The service(s) indicated in Part B, must be activated within 30 days from the date signed above.

Please send this completed form to one of the Approved Home Medical Services Agencies. A complete list of agencies can be found on the Health Council website at: http://www.bhec.bm/reimbursement-rates/