For Bay Area Mobile Medical Group use only

Medicare Part B Eligible **Y** **N**

Note: _____

Visit Date/Time: _____

Provider's Name: _____

INTAKE FORM

HOME HEALTH/OFFICE NAME: _____ DATE: _____
CONTACT PERSON: _____ PHONE NO: _____
FAX: _____ EMAIL: _____

PATIENT'S INFORMATION

(LAST NAME) (FIRST NAME)

NAME: _____ **GENDER:** ☐ Male ☐ Female

ADDRESS: _____ **DATE OF BIRTH:** _____

_____ **NATIONALITY:** _____

_____

CONTACT NO/NOS. : _____

INSURANCE INFORMATION

PRIMARY INSURANCE: **MEDICARE PART B** **MBI**: _____

*If MBI (Member Beneficiary Identifier) not available, please provide **SSN***: _____

REASON FOR REFERRAL

☐ **DISCHARGED FROM HOSPITAL**
NAME OF HOSPITAL/DATE OF DISCHARGE: _____
☐ **REFERRAL TO HOME HEALTH**
☐ **REFERRAL TO HOSPICE**
☐ **AMBULATORY DEVICES:**
___ **CANE** ___ **WHEEL CHAIR** ___ **OTHERS:** _____

REMARKS: _____

_____

Please complete this form in its entirety for faster service

BAY AREA MOBILE MEDICAL GROUP

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