Request for Transfer from Another Agency

Patient Name: ____

This above named patient/authorized representative has indicated a choice to transfer their

Home Care Services from: ____ to

WellsBrooke Certified Home Health Care effective as of: ____________________(Date).

The patient/authorized representative understands that the initial agency will no longer receive payment from Medicare and will no longer provide Medicare covered services beginning on the effective date of the elected transfer. WellsBrooke has notified the initial agency of the elected transfer and the effective date of services. Medicare will provide payment to WellsBrooke Certified Home Health Care for Medicare covered services beginning on the effective date.

If you have questions regarding your insurance coverage or Medicare benefits, please call us at 419-931-9930.

____ ____________________
(Patient/Authorized Representative Signature) (Date)

____ ____________________
(Staff Signature) (Date)

830 W. South Boundary, Suite C • Perrysburg, OH 43551 • Phone: 419.931.9930 • Fax: 419.931.9931