

All Inclusive Home Health
Your Address, USA
Phone:
Fax:

**Request for Clarification of
Medicare Coding and Documentation**

To: _____ **Fax #** _____

Patient Name: _____ **DOB:** _____ **Admission Date:** _____

Our agency is required under Medicare and ICD-10-CM coding guidelines to accurately assign specific diagnosis codes when submitting OASIS data and the claim.

We are currently providing home health care to this patient for management of **lower extremity ulcer(s)** located on: _____.

The admitting clinician (_____) has provided additional information from the onsite clinical assessment:

In order to ensure that your patient's record accurately reflects the diagnosis for which we are providing care, please provide further information about **etiology** related to this patient's **lower extremity ulcer(s)** by initialing the appropriate underlying condition:

- | | |
|--|--|
| <input type="checkbox"/> Atherosclerosis of LE | <input type="checkbox"/> Venous insufficiency (chronic) (peripheral) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Postphlebotic syndrome |
| <input type="checkbox"/> Chronic venous hypertension | <input type="checkbox"/> Postthrombotic syndrome |
| <input type="checkbox"/> Varicose ulcer | <input type="checkbox"/> Etiology cannot be determined |
| | <input type="checkbox"/> Other etiology (specify): _____ |

Additional Physician Clarification / Comment:

Once completed, sign and date this form and add it to your medical record. Return a signed and dated copy to our agency. Should we not hear from your office within the next 24 hours we will follow up with a phone call to clarify this diagnosis.

Physician Signature **Date:** _____

Thank you for helping us to maintain a record that accurately reflects the patient's condition(s) for which you have ordered home health services.

Clinician/Coder **Date:** _____ **Phone:** _____

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