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:

___ Atherosclerosis of LE
___ Diabetes
___ Chronic venous hypertension
___ Varicose ulcer
___Venous insufficiency (chronic) (peripheral)
___ Postphlebetic syndrome
___ Postthrombotic syndrome
___ Etiology cannot be determined
___ 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.

_____ **Date: _____**

Physician Signature

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.

_____ **Date: _____ Phone: _____**

Clinician/Coder