



**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE
PHYSICIAN ORDER FORM (POF)
FOR MEDICAID SERVICES**



Physician is to complete applicable sections and fax to Delmarva Foundation at 202-698-2075.

SECTION I: PATIENT INFORMATION

A. PATIENT D.C. MEDICAID NUMBER:		B. NAME (LAST, FIRST, M.I.): (PRINT)	C. PERMANENT ADDRESS:
D. TELEPHONE NUMBER: _____-_____-_____		E. DATE OF BIRTH: _____/_____/_____	F. SEX: <input type="checkbox"/> M <input type="checkbox"/> F
G. PATIENT LOCATION AND ADDRESS ON DATE OF ORDER: <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL (name): _____ <input type="checkbox"/> NURSING FACILITY (name): _____ <input type="checkbox"/> OTHER (name): _____ IF IN A FACILITY, EXPECTED DATE OF DISCHARGE: ____/____/_____ ADDRESS TO WHICH PATIENT WILL BE DISCHARGED:		H. DOES PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following: (To be completed by Delmarva Foundation staff providing face to face comprehensive assessment) PLAN NAME AND POLICY NUMBER: NAME OF POLICY HOLDER: PLAN ADDRESS AND TELEPHONE NUMBER: I. DATE OF ORDER: ____/____/_____	

SECTION II: PHYSICIAN INFORMATION

A. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER:	A. DC MEDICAID PROVIDER NUMBER:
B. PHYSICIAN NAME (LAST, FIRST, M.I.): (PRINT)	B. PHYSICIAN ADDRESS:
C. TELEPHONE NUMBER: _____-_____-_____	C. FAX NUMBER: _____-_____-_____

SECTION III: TYPE OF SERVICES

<input type="checkbox"/> PERSONAL CARE AIDE (PCA) SERVICES		<input type="checkbox"/> ADULT DAY HEALTH PROGRAM (ADHP) SERVICES	
A. Is patient unable to independently perform one or more activities of daily living for which PCA services are needed? <input type="checkbox"/> Yes <input type="checkbox"/> No		A. Is patient 55 years or older with a chronic medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
B. Does patient have a medical condition or cognitive impairment that limits activities of daily living? <input type="checkbox"/> Yes <input type="checkbox"/> No		B. Does patient have a chronic condition that is expected to last a year or more and requires ongoing medical attention and/or limits activities of daily living? <input type="checkbox"/> Yes <input type="checkbox"/> No	
C. Please list all medical and cognitive conditions:		C. Please list all chronic medical conditions:	
ICD DIAGNOSIS CODE(S):		ICD DIAGNOSIS CODE(S):	

SIGNATURE OF ORDERING PHYSICIAN: _____	DATE _____
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