



VNA Health at Home – Home Care  
2464 Fortune Drive, Suite 110  
Lexington, KY 40509  
P: 859-277-5111 F: 859-278-0597

### Fax Lead Sheet

DATE: 7/28/25

ATTENTION: Todd McGrath

COMPANY: \_\_\_\_\_

FAX NO: 859-399-6697

PHONE NO: \_\_\_\_\_

RE: New Referral

MESSAGE:

NUMBER OF PAGES: \_\_\_\_\_ (Including Lead Sheet)

FROM: VNA HEALTH AT HOME

PHONE NO: 859-277-5111

**THANK YOU!**

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**RETURN FAX NUMBER:** 859-278-0597 or 888-218-1137

## Patient Information Report

<b>Patient:</b>	HAWKINS, JAMES	<b>Insured ID:</b>	8FW5K54TJ63	<b>Primary Payor:</b>	MEDICARE PDGM
<b>MR No:</b>	04200070755601				
<b>Legacy MR No:</b>					

<b>Assigned Branch</b>	VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGTON	<b>Assigned Team</b>	TEAM B	<b>Location</b>	
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<b>Patient Nickname</b>		<b>Patient ID</b>	707556	<b>SSN</b>	
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**Referral Info**

<b>Referral Date</b>	03/10/2025	<b>Referral Type</b>	RECERTIFICATION	<b>Referral Taken By</b>	3/6/25
<b>Referral Source</b>		<b>Referring Physician</b>		<b>Referring Physician Contact</b>	
PHYSICIAN		WILLIAMS, MICHELLE		MICHELLE WILLIAMS	

**Care Type and Effective Date - (P-Primary)**

HOME HEALTH 07/08/2025 - (P)  
RSP2 07/08/2025 -

**Demographics****Patient Info**

<b>Gender</b>	MALE	<b>DOB</b>	08/01/1947	<b>Race</b>	
<b>Preferred Language</b>					
<b>Primary Phone</b>		<b>Alt Phone</b>		<b>Email</b>	JAMES

**Primary Address**

<b>Street</b>		<b>City</b>	WINCHESTER	<b>State</b>	<b>Zip</b>	<b>County</b>
201 STEVE CIRCLE				KY	40391-	CLARK
<b>Phone</b>	<b>MSA #</b>	<b>CBSA</b>		<b>Floor</b>		<b>Room</b>
(636) 448-2583		30460				
<b>Travel Directions</b>						

**Current Service Location: CLIENT'S HOME/RESIDENCE**

<b>Street</b>		<b>City</b>	WINCHESTER	<b>State</b>	<b>Zip</b>	<b>County</b>
201 STEVE CIRCLE				KY	40391-	CLARK
<b>Phone</b>	<b>MSA #</b>	<b>CBSA</b>		<b>Floor</b>		<b>Room</b>
(636) 448-2583		30480				
<b>Travel Directions</b>						

**Patient Contacts**

<b>Contact Name</b>	<b>Relationship</b>	<b>Contact Type</b>	<b>Contact Relationship Type</b>
MRS HAWKINS	SPOUSE	PRIMARY CAREGIVER	PRIMARY CAREGIVER
<b>Home Phone</b>	<b>Primary Phone</b>	<b>Alternate Phone</b>	<b>Address</b>

**Payor Source Info**

<b>Payor Source Type</b>	<b>Payor Type</b>	<b>Payor Source</b>	<b>Is patient in an HMO (HHCAPHS)?</b>
PRIMARY	MEDICARE	MEDICARE PDGM	
<b>Medicare No.</b>	<b>Medicare A Effective</b>	<b>Medicare B Effective</b>	<b>Admission Source</b>
8FW5K54TJ63			1 - PHYSICIAN REFERRAL
<b>Medicaid No.</b>	<b>Medicaid Effective</b>	<b>Physician Medicaid No.</b>	<b>Physician Name</b>
			MANNING, THAD

**Private Payor Type Info**

<b>Claim No.</b>	<b>Policy No.</b>	<b>Insured ID</b>		
<b>Insured Name</b>	<b>Insured Relation</b>	<b>Insured Address</b>		
		<b>Insured City</b>	<b>Insured State</b>	<b>Insured Zip</b>

## Patient Information Report

**Patient:** HAWKINS, JAMES  
**MR No:** 04200070755601  
**Legacy MR No:**  
**Insured ID:** 8FW5K54TJ63  
**Primary Payer:** MEDICARE PDGM

**Employer Name**  
**Employer ID**  
**Insured Phone**  
**Employer Address**  
**Employer City** **Employer State** **Employer Zip**  
**Employer Phone**

**Program Name** **Obtained Date** **Obtained By/ Authorized By** **Authorization No./ Active** **Start Date/ End Date**  
 PPS PROGRAM 6/29/2025 10:23:04 PM HCHB RECERTIFICATION Y 07/08/2025 09/05/2025

**Unit Type** **Budget Type** **Billing Code** **Qty Per Period** **Qty Per Day** **Qty Per Week** **Qty Per Month** **Qty Per Year** **Active**  
 VISITS DISCIPLINES SN 11 Y

## Physician Info

**Primary Physician** **NPI #** **Date Last Seen**  
 MANNING, THAD 1053499673  
**Address** **City** **State** **Zip**  
 1520 BOONESBORO RD WINCHESTER KY 40391-  
**Phone** **Fax** **Pager**  
 (859)744-0067 (859)744-0042  
**Secondary Physician** **Perform Add-On Evaluation Prior to Approval of the Plan of Care associated with the Completed SOC Visit?**  
 WILLIAMS, MICHELLE  
**Requested Date of Evaluation** **Admitting Discipline** **Completed SOC Visit?**  
 07/08/2025 SN N  
**Requested Date of Add-On Evaluation** **Add-On Discipline**

## Clinical Info

**Case Manager** **Team Member(s)**  
 JULIE TAYLOR, RN BRAUN APPLGATE, PT  
 CLARENCE SKEENS, PTA  
 JOHN LEAR-PHILLIPS, OT  
 SHANNON FISHER, LPN

**Weight** **Height** **Pregnant** **Paperwork Received By Patient**  
 N Y

## Medical Release Code

YES, PROVIDER HAS A SIGNED STATEMENT PERMITTING RELEASE OF MEDICAL BILLING DATA RELATED TO A CLAIM

**Acuity Status** **Disaster Status** **Evacuation Location**  
 1 - SAME DAY AMBULATORY W/ ASSIST WILL GO TO DAUGHTER'S HOME

**Type** **Location** **Contents** **Contact Name** **Contact Phone** **Was Adv Dir Info Left With Caregiver?**  
 DO NOT RESUSCITATE HOME Y