

## McGRATH MEDICAL WOUND CARE



## INTAKE FORM

Personal InformationFull Name\* Marilyn P WebberPhone Number: 859-251-6060 Email Address: \_\_\_\_\_Address: 912 Delaney Ferry Rd Versailles, Ky 40383

Best Time To Contact:

Preferred Days:

Preferred Time:

Please use the below space to share notes such as veteran status, senior, in home or in office visit preferences etc.

Notes: ~~former~~ Senior in home  
\_\_\_\_\_  
\_\_\_\_\_POA Contact DetailsContact Name: John Webber Phone Number: 859-753-6676Relationship: Spouse Email Address: \_\_\_\_\_

\*READ DISCLAIMER TO PATIENT\*

Rep Information

Full Name / Rep#

Phone Number:

Email:

859-399-6697

## Questions?

Call (859) 492-1579 OR (859) 285-9536

## Patient Information Report

<b>Patient:</b>	WEBBER, MARILYN P	<b>Insured ID:</b>	H08069210	<b>Primary Payor:</b>	HUMANA MCR ADV PDGM
<b>MR No:</b>	04200053148301	<b>Insured ID:</b>		<b>Secondary Payor:</b>	SELF PAY
<b>Legacy MR No:</b>					

<b>Assigned Branch</b>	VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGTON	<b>Assigned Team</b>	TEAM A	<b>Location</b>	
<b>Patient Nickname</b>		<b>Patient ID</b>	531483	<b>SSN</b>	

<b>Referral Date</b>	04/08/2025	<b>Referral Type</b>	RECERTIFICATION	<b>Referral Taken By</b>	INTERFACE
<b>Referral Source</b>		<b>Referring Facility</b>		<b>Referring Facility Contact</b>	
<b>FACILITY</b>		<b>SAINT JOSEPH HOSPITAL LEXINGTON</b>		<b>DISCHARGE PLANNER</b>	

**Care Type and Effective Dates (Per Primary)**

HOME HEALTH 08/08/2025 - (P)  
CARELINK - DIABETES 08/08/2025 -  
CARELINK - CARDIO 08/08/2025 -  
IV 08/08/2025 -  
RSP2 08/08/2025 -

**Demographics****Patient Info**

<b>Gender</b>	FEMALE	<b>DOB</b>	10/05/1947	<b>Race</b>	
<b>Preferred Language</b>					
<b>Primary Phone</b>	8592516060	<b>Alt Phone</b>		<b>Email</b>	MARILYN

**Primary Address**

<b>Street</b>		<b>City</b>	VERSAILLES	<b>State</b>	KY	<b>Zip</b>	40383-	<b>County</b>	WOODFORD
<b>Phone</b>	<b>MSA #</b>	<b>CBSA</b>		<b>Floor</b>				<b>Room</b>	
(859)251-6060		30460							
<b>Travel Directions</b>									

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

<b>Street</b>		<b>City</b>	VERSAILLES	<b>State</b>	KY	<b>Zip</b>	40383-	<b>County</b>	WOODFORD
<b>Phone</b>	<b>MSA #</b>	<b>CBSA</b>		<b>Floor</b>				<b>Room</b>	
(859) 251-6060		30460							
<b>Travel Directions</b>									

**Patient Contacts**

<b>Contact Name</b>	<b>Relationship</b>	<b>Contact Type</b>	<b>Contact Relationship Type</b>
JOHN WEBBER	SPOUSE	POWER OF ATTORNEY - PHI APPROVED	PRIMARY CAREGIVER
<b>Home Phone</b>	<b>Primary Phone</b>	<b>Alternate Phone</b>	<b>Address</b>
	(859) 251-6060	(859) 753-8876	

**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	MANAGED MEDICARE PPS / PDGM	HUMANA MCR ADV PDGM	N
<b>Medicare No.</b>	<b>Medicare A Effective</b>	<b>Medicare B Effective</b>	<b>Admission Source</b>
1NV8C25EH51			1 - PHYSICIAN REFERRAL
<b>Medicaid No.</b>	<b>Medicaid Effective</b>	<b>Physician Medicaid No.</b>	<b>Physician Name</b>
			HURT, BUDDY

**Payor Source Info**

<b>Payor Source Type</b>	<b>Payor Type</b>	<b>Payor Source</b>	<b>Is patient in an HMO (HHCAPHS)?</b>
SECONDARY	SELF PAY	SELF PAY	

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<b>Legacy MR No:</b>					

<b>Medicare No.</b>	<b>Medicare A Effective</b>	<b>Medicare B Effective</b>	<b>Admission Source</b>
			1 - PHYSICIAN REFERRAL
<b>Medicaid No.</b>	<b>Medicaid Effective</b>	<b>Physician Medicaid No.</b>	<b>Physician Name</b>
			HURT, BUDDY

## Private Payor Type Info

<b>Claim No.</b>	<b>Policy No.</b>	<b>Insured ID</b>			
	H08069210				
<b>Insured Name</b>	<b>Insured Relation</b>	<b>Insured Address</b>			
		<b>Insured City</b>	<b>Insured State</b>	<b>Insured Zip</b>	
		<b>Insured Phone</b>			

## 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>			
WEBBER, MARILYN	SELF	912 DELANEY FERRY RD			
		<b>Insured City</b>	<b>Insured State</b>	<b>Insured Zip</b>	
		VERSAILLES	KY	40383-	
		<b>Insured Phone</b>			
		(859) 251-6060			
<b>Employer Name</b>	<b>Employer ID</b>	<b>Employer Address</b>			
		<b>Employer City</b>	<b>Employer State</b>	<b>Employer Zip</b>	
		<b>Employer Phone</b>			
<b>Employer Name</b>	<b>Employer ID</b>	<b>Employer Address</b>			
		<b>Employer City</b>	<b>Employer State</b>	<b>Employer Zip</b>	
		<b>Employer Phone</b>			

<b>Program Name</b>	<b>Obtained Date</b>	<b>Obtained By/ Authorized By</b>	<b>Authorization No/ Active</b>	<b>Start Date/ End Date</b>
PPS PROGRAM	7/28/2025 9:31:19 AM	HCHB RECERTIFICATION	Y	08/08/2025 10/06/2025

<b>Unit Type</b>	<b>Budget Type</b>	<b>Billing Code</b>	<b>Qty Per Period</b>	<b>Qty Per Day</b>	<b>Qty Per Week</b>	<b>Qty Per Month</b>	<b>Qty Per Year</b>	<b>Active</b>
VISITS	DISCIPLINES							Y
PPS PROGRAM	8/18/2025 8:58:46 AM	JENNIFER WESLEY, Elsabet				213464817 Y		08/08/2025 10/06/2025
<b>Unit Type</b>	<b>Budget Type</b>	<b>Billing Code</b>	<b>Qty Per Period</b>	<b>Qty Per Day</b>	<b>Qty Per Week</b>	<b>Qty Per Month</b>	<b>Qty Per Year</b>	<b>Active</b>
VISITS	DISCIPLINES	HHA	60					Y
VISITS	DISCIPLINES	MSW	60					Y
VISITS	DISCIPLINES	OT	60					Y
VISITS	DISCIPLINES	PT	60					Y

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<b>Legacy MR No:</b>					

<u>Program Name</u>	<u>Obtained Date</u>	<u>Obtained By/ Authorized By</u>	<u>Authorization No./ Active</u>	<u>Start Date/ End Date</u>
VISITS	DISCIPLINES SN	60		Y
VISITS	DISCIPLINES ST	60		Y

**Physician Info**

<b>Primary Physician</b>	<b>NPI #</b>	<b>Date Last Seen</b>
HURT, BUDDY	1366479248	
<b>Address</b>	<b>City</b>	<b>State</b> <b>Zip</b>
117 CROSSFIELD DR SUITE B FAMILY MED WOODFORD	VERSAILLES	KY      40383-
<b>Phone</b>	<b>Fax</b>	<b>Pager</b>
(859)873-9188	(859)873-0870	

<b>Secondary Physician</b>	<b>Perform Add-On Evaluation Prior to Approval of the Plan of Care associated with the Completed SOC Visit?</b>
PIERCY, ELIZABETH	N
<b>Requested Date of Evaluation</b>	<b>Admitting Discipline</b>
08/08/2025	SN
<b>Requested Date of Add-On Evaluation</b>	<b>Add-On Discipline</b>

**Clinical Info**

<b>Case Manager</b>	<b>Team Member(s)</b>
MANDI MCBRIDE, RN	CHERYL COOK, LPN GRETCHEN OLDS-ROENTZ, OT MEGAN KIFER, PTA WALTER LUTTRELL, PT

<b>Weight</b>	<b>Height</b>	<b>Pregnant</b>	<b>Paperwork Received By Patient</b>
		N	Y

**Medical Release Code**

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

<b>Acuity Status</b>	<b>Disaster Status</b>	<b>Evacuation Location</b>
3 - WITHIN WEEK	CHAIR BOUND	SISTER IN LAW

<u>Type</u>	<u>Location</u>	<u>Contents</u>	<u>Contact Name</u>	<u>Contact Phone</u>	<u>Was Adv Dir Info Left With Caregiver?</u>
LIVING WILL	IN HOME				N

**Inpatient Events (Unaffiliated with your Agency)**

<u>Inpatient Facility</u>	<u>Hospital Admit Date</u>	<u>Hospital Discharge Date</u>	<u>Surgery Date</u>	<u>Inpatient MR No.</u>	<u>Reason for Admission</u>
SAINT JOSEPH HOSPITAL LEXINGTON	04/03/2025	04/08/2025			UTI

**Home Health Care Survey**

<b>Is care related to surgical discharge?</b>	<b>Does patient have end-stage renal disease?</b>	<b>Number of ADLs for which patient is not independent?</b>
<b>Has patient requested "No Publicity" status?</b>	<b>Is maternity care the primary reason for home health care?</b>	<b>Primary Spoken Language</b>
N	N	

Sep. 9. 2025 6:57AM

No. 4337 P. 6/6

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ICD-10 Diagnosis Procedure							
Order	Code	Description	Onset / Exac.	O/E Date	Type	Sym. Ctrl. Rtg.	OASIS Item
1	L89.154	PRESSURE ULCER OF SACRAL REGION, STAGE 4	E	06/05/2025	D	2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring.	M1021
2	E11.9	TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS	O	06/05/2025	D	1 - Symptoms well controlled with current therapy.	M1023
3	G35	MULTIPLE SCLEROSIS	O	06/05/2025	D	1 - Symptoms well controlled with current therapy.	M1023
4	I11.0	HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	O	06/05/2025	D	1 - Symptoms well controlled with current therapy.	M1023
5	I50.9	HEART FAILURE, UNSPECIFIED	O	06/05/2025	D	1 - Symptoms well controlled with current therapy.	M1023