REQUEST FOT TRANSFER FROM ANOTHER AGENCY

Patient Name: _____ MR#: _____

Medicare #: _____ Other Insurance: _____

Name of Other Home Care Agency: _____

I, _____ am requesting to transfer from _____

_____to Sphinx Home Health Care, effective ____ / ____ / _____.

I understand that my insurance will no longer pay the former agency effective from the date mentioned above and that they will no longer provide me with Home Health Care services. Sphinx Home Health Care will now be my Home Care provider and will bill my insurance on my behalf for all covered services.

Patient Signature: _____ Date: ____ / ____ / _____

Staff Signature: _____ Date: ____ / ____ / _____

4415 Metro Parkway, Ste 200, Sterling Heights, MI 48310 | Ph (586)264-2400 | Fax (586)264-2919