

Home Rehab Network **Fax**

Online Pulmonary Rehab

Referral Extension Request

WWW.HOMEREHABNETWORK.COM

Patient Name: _____ DOB: _____

This is a request for an updated referral for your patient to continue online pulmonary rehabilitation based on medical necessity. This program remains essential for managing your patient's pulmonary condition and ensuring continued progress. **Please sign this form and fax it back to us at your earliest convenience.**

Pulmonary Diagnosis

- | | |
|---|--|
| <input type="checkbox"/> COPD / Emphysema | <input type="checkbox"/> Chronic Bronchitis |
| <input type="checkbox"/> COPD / Asthma Overlap Syndrome | <input type="checkbox"/> Bronchiectasis |
| <input type="checkbox"/> Chronic Respiratory Failure | <input type="checkbox"/> Pulmonary Fibrosis |
| <input type="checkbox"/> Lung Transplant Status | <input type="checkbox"/> Interstitial Lung Disease |
| <input type="checkbox"/> Aftercare Following Lung Transplant | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Post COVID-19 Condition, Unspecified | <input type="checkbox"/> Other Lung Disease / Cancer |
| <input type="checkbox"/> Post COVID-19 Pneumonia | Other: _____ |

Provider Information

Provider Signature: _____

Please Print Name: _____

Date: _____ Fax to **410-871-4022**

CONTACT US

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