



Physician Documentation of Face to Face Encounter

(Must occur within 90 days before SOC date of ____/____/____ for Medicare coverage.)

Patient Name and DOB: _____

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: (Insert date that visit occurred): _____

(Month/Day/Year)

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care (List medical condition):

I certify that, based on my findings, the following services are medically necessary home health services.

(Check all that apply):

- Nursing Home Health Aide Physical Therapy
 Medical Social Worker Speech Language Pathology Occupational Therapy

My clinical findings support the need for the above services because:

Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons) because:

Physician Signature: _____

(CMS MANDATES PA'S, NP'S, CLINICAL SPECIALISTS MAY NOT SIGN)

Date of Signature: _____

Physician Printed Name: _____