PHYSICIAN FACE-TO-FACE ENCOUNTER FORM

Patient Name: _____ Date of Birth: _____

Date of Face-to-Face Encounter: I certify that this patient is under my care and that I, or a Nurse Practitioner or Physician Assistant working with me, had a face-to-face encounter with this patient that meets the physician face-to-face encounter requirements (please insert date that visit occurred).

_____
Month Day Year

Medical Condition: The encounter with the patient was in whole, or in part, for the following medical condition which ls the primary reason for home care. (Please list ALL medical conditions).

_____

_____

_____

Medical Necessity: I certify, that based on my findings, the following services are medically necessary home care services (Please check all that apply).

___ Nursing ___ Occupational Therapy

___ Physical Therapy ___ Home Health Aide

___ Speech Language Pathology ___ Other: _____

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

_____

_____

_____

Homebound Status: Further, I certify that my clinical findings support that this patient is homebound because:

_____

_____

_____

Physician Signature: _____Date: _____

Physician Printed Name: _____