HOME HEALTH FACE-TO-FACE ENCOUNTER CERTIFICATION

Patient Name: _____

Admission ID: _____

Physician Signing Certification: _____

Physician NPI: _____

Home Care Agency: _____

☐ I, a Medicare-enrolled physician, **or** a ☐ non-physician practitioner* *(CHECK ONE)*

had a face-to-face encounter with the above-named patient on _____/_____/_____
(Date of Encounter)

for the following medical condition(s) _____,

which is related to the primary reason the patient needs home care.

The following clinical findings support that the patient is homebound *(homebound means that there exists a normal inability to leave home, and consequently, leaving home requires considerable and taxing effort)* **and that the patient needs intermittent skilled nursing and/or therapy** *(physical or occupational therapy or speech pathology)*:

Homebound: _____

_____

_____

Skilled Need: _____

_____

_____
Physician Signature

_____
Date

* Per CMS's regulation (42 C.F.R §424.22), "the physician responsible for performing the initial certification must document that the face to face patient encounter, which is related to the primary reason the patient requires home health services, has occurred." This documentation must include the "date of the encounter, an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing or therapy services as defined in § 409.42 (a) and (c)."

** A non-physician practitioner includes a nurse practitioner, clinical nurse specialist working in collaboration with the physician, a certified nurse midwife or a physician assistant under the supervision of the physician.

HOME HEALTH CARE FAX: 718-682-0055

PATIENT INFORMATION

Last Name: _____ First: _____ ☐ Male ☐ Female D.O.B. _____

Address: _____

City: _____ State: _____ Zip: _____

Tel. #: _____ S.S. # _____ Language Spoken: _____

Emergency Contact/Relationship: _____

Lives with: ☐ Alone ☐ Family ☐ Caregiver **Mental Status:** ☐ Oriented ☐ Confused ☐ Forgetful

INSURANCE INFORMATION:

Medicare #: _____ Medicaid # _____

SERVICES REQUESTING:

☐ Nursing ☐ Physical Therapy ☐ Speech Therapy
☐ Aide: HHA ☐ Occupational Therapy ☐ Social Work
Hours: ____ Days: ____

DIAGNOSIS:

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS/DOSE/FREQUENCY

1. _____
2. _____
3. _____
4. _____
5. _____

PHYSCIAN INFORMATION:

Last Name: _____ First: _____ M.I. _____
Address: _____ City: _____ State: _____ Zip: _____
Tel. #: _____ License #: _____ UPIN #: _____ NPI #: _____
Doctors Orders: _____

☐ DM only BG Parameters _____ ☐ PT only WB Status _____
☐ Wound Care Orders _____
MD Signature: _____ Date _____