Company Name

FACE-TO-FACE ENCOUNTER FOR HOME CARE

To be filled out by the home care agency.

Patient D.O.B.: ___/___/_____

Patient Name - Last, First, Middle Initial: _____ ID#: _____

QUALIFYING ENCOUNTER TYPE (check applicable type)

☐ 1. Hospitalist provider conducted the face-to-face encounter and certification.
Date conducted ___/___/_____ Provider's name: _____
Copy of face-to-face certification documentation requested/obtained: ☐ Yes ☐ No

☐ 2. Face-to-face encounter conducted within 90 days of home care SOC.
Date conducted ___/___/_____ Provider's name: _____
Copy of face-to-face certification documentation obtained: ☐ Yes ☐ No

☐ 3. Face-to-face encounter was conducted within 30 days of the SOC.
SOC Date: ___/___/_____ Date of 30th day: ___/___/_____
Date of visit: ___/___/_____
Was physician's office contacted to verify appointment and purpose of appointment? ☐ Yes ☐ No
If Yes date contacted: ___/___/_____ By whom: _____
If No explain: _____

Additional information: _____

To be filled out by physician conducting the initial certification/face-to-face encounter.

PHYSICIAN ATTESTATION

Home Health Certifying Physician *(print name):* _____

I certify that this patient is under my care and that I, or a nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements on: Date: ___/___/_____

Non-Physician Practitioner Name: _____ License No. _____

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 *(Describe):*

_____

_____

_____

_____

My clinical findings support the need for the services listed below because:

_____

_____

_____

I certify that my clinical findings support that this patient is homebound* because:

_____

_____

_____

*(*i.e. Patient has normal inability to leave the home and absences from home require considerable and taxing effort, are for medical reasons or religious services or infrequently or of short duration when for other reasons.)*

I certify that the following home care services are medically reasonable and necessary: *(Check all that apply):* ☐ Nursing ☐ Therapy

Physician, please sign and return within 2 days.

Physician's Signature: _____ Date of Signature: ___/___/_____

Physician's Name: _____

PART 1 - To Physician (For Signature) PART 2 - Clinical Record (Temporary Copy)