Partners IN HOME CARE | BRINGING HEALTHCARE HOME

Home Health Face-to-Face Form

Patient Name: ____ 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):** ______________________________

The encounter with the patient was directly related to the **following medical condition(s)**, which is the **primary reason for home health care** (List medical condition):

____

For Hospitalist or Emergency Room Physician: Name of Accepting MD: _________________________

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

___ Nursing ___ Occupational Therapy

___ Physical Therapy ___ Certified Nursing Assistant

___ Speech Therapy ___ Social Worker

Support of Patient's Medical Necessity

Provide a summary of **clinical interventions or treatments** that support medical necessity for the home health services to be provided by the above disciplines:

Statement of Homebound Status

Further, I certify that the patient's clinical condition supports that the **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) **due to:** (**describe patient's functional limitation and why they need assist to leave the home.**)

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

Physician Signature: _______________________________________ Date: _______________

Printed Name: ____

Please Fax to (406) 549-8970