

HOME HEALTH ORDER/FACE-TO-FACE ENCOUNTER DOCUMENT

Patient Name: _____ Phone: _____

Address: _____

Patient DOB: _____ Medicare/Insurance #: _____

Contact Person: _____ Phone: _____

Face-to-Face encounter date: _____

Primary medical condition(s)/diagnosis requiring Home Health: _____

Based on my clinical findings/diagnosis, the patient will require the following services:

RN, PT, OT, ST, MSW, HHA for _____

I certify my clinical findings/diagnosis support that this patient is HOMEBOUND per CMS guidelines.

Criteria 1: The patient requires the following assistance to leave home alone: _____

OR, Patient has a medical condition that is medically contraindicated: _____

Criteria 2: The patient has a normal inability to leave home due to: _____
and doing so requires taxing, and considerable effort. Because of the patient's health status, patient is dependent on the use of a device, such as Cane, walker, wheelchair, assistance of another person while using _____ or is bedbound.

I certify that this patient is under my care and that I, or another qualified provider, had a face-to-face encounter with this patient on the above date. My clinical findings support that the patient is home bound and has a need for intermittent skilled nursing, physical therapy, and/or speech therapy, or a continued need for occupational therapy services in the home for his/her current diagnosis as outlined in the initial plan of care/progress notes. These services will continue to be monitored by myself or another physician who will periodically review and update the plan of care as required.

1. If you will not be following this patient's care for home health services, please identify the physician in the community who will be taking over this patient's plan of care:

Primary Physician's Name: _____

Certifying Physician Signature: _____ Name: _____

Address: _____

Date: _____ Phone: _____ Fax: _____