Home Health Referral and Documentation of Face-to-Face Encounter

Patient Name	Patient Sex M/F	DOB ___/___/_____	Patient Address
Patient Phone #	Responsible Relative of Friend Name: Relationship		Phone #
Medicare Number	Medicaid Number	Notes:	

Please fax the completed form and include the following information:

- ✓ **A progress note or a visit note from the clinical encounter dated in section 1 below (Face-to-Face).**
- ✓ **A list of patient's relevant medical history (i.e. problem list).**
- ✓ **Current patient demographics and medication list.**
- ✓ **Any other pertinent medical records.**

1. **Certification and Date of Face-to-Face Encounter**
   I certify/re-certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care, and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred _____(**Date of Encounter**), or will occur, within time frame requirements *and* it is related to the primary reason the patient requires home health services.

2. **Medical Condition Related to Home Health Services**
   The encounter with the patient was in whole, or in part, for the following medical condition(s), which is the primary reason for home health care **(list medical conditions):**
   _____
   _____
   _____
   _____

3. **Additional clinical findings that support the medical necessity:** You may include additional clinical findings to support the skilled services needed**:**
   _____
   _____
   _____

4. **Certification of Medical Necessity and services ordered:** I certify that, based on my clinical findings, the following services are medically necessary home health services:

   ☐Skilled Nursing ☐Physical Therapy ☐Occupational Therapy ☐ Speech Language Therapy ☐Home Health Aide Services ☐ Medical Social Work

5. **Certification of Homebound Status:** My clinical findings from this encounter support the patient is homebound. I certify that this patient meets homebound status.

   Patient is confined because of illness, needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

   Patient has a normal inability to leave home.

   AND

   Leaving home requires a considerable and taxing effort for the patient.

Physician Signature: **Date of Signature: __/__/____** **Time of Signature: ----/---- AM/ PM __**

Physician Printed Name: **Physician's Phone Number:**

Please send this form and the documents noted before section 1.