FACE-TO-FACE ENCOUNTER FOR HOME CARE

To be filled out by the home care agency

Patient D.O.B.: _____

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 will be conducted within 30 days of the SOC.
SOC date: _____ Date of 30th day: _____
Date of scheduled 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 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 or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements on. Date: _____

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 *(List medical condition)*:

_____

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., 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.)*

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

Physician to sign and return within 2 days

Physician's signature: _____ Date of signature: _____

PART 1— To Physician (for signature)	PART 2— Clinical Record (temporary copy)
PATIENT NAME (Last, First, Middle Initial)	**ID #**