



FACE-TO- FACE ENCOUNTER

_____ / ____ / ____
PATIENT NAME Date of Birth

I certify the above 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 below requirements with this patient on:

____ / ____ / ____ * **Date of Face-to-Face Encounter** (*has to occur no more than 90
Month Date Year days prior to home health start of care date or within 30 days of
the start of home health care)

Medical condition requiring Face-to-Face Encounter, which is primary reason for home health care referral:

_____ List medical condition requiring Face-to-Face Encounter and Reason for Home Care

I certify, based on my findings, the following services are medically necessary home health services (**Check all that apply**):

- _____ Nursing
- _____ Physical Therapy
- _____ Speech language pathology

My clinical findings support the need for the above services **because:**

Further, I certify that my clinical findings support that this 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) **because:**

Physician Signature _____

Date of Signature _____ / _____ / _____

Physician Printed Name _____

Face-to-Face Encounter is a requirement for Medicare Beneficiaries receiving Home Health. Form must be completed in entirety to meet Medicare Regulations and allow our agency to bill for home care services.