

Face to Face Patient Encounter
(Addendum to Patient Plan of Care)

Patient Name: _____ **DOB:** _____

Address: _____
Street Address City, State, Zip

I certify that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter with the patient identified above. This encounter met Medicare's face-to-face patient encounter requirements:

Encounter Date: _____
Please enter Date visit occurred (Month/ Day/ Year)

Medical Condition which is the **Primary Reason** for home health care: _____

Clinical Findings that support the need for home health care services:

I certify that the following initial home health care services are medically necessary:

- Skilled Nursing Physical Therapy Speech Therapy

Homebound Status: I certify that my clinical findings support that this patient is **homebound** (i.e. absence from home require considerable and taxing effort and are for medical reasons or religious services or infrequent or of short duration when for other reasons) because:

Please check ONE of the following:

- I will be treating the patient on an ongoing basis. Please send me the Plan of Care for signature.
 I treated the patient in an acute care facility and **will not** continue treatment after discharge.

The following community physician identified for follow-up care: _____
(PLEASE PRINT)

Physician Name (PRINT): _____

Physician Signature: _____ **Date Signed:** _____