Face-to-Face Encounter Documentation

Patient Name (Last Name, First Name) & MRN:

Gender: ○ M ○ F

DOB: / /

Agency Name/Branch:

Agency FAX:

Please complete, sign and return to the home health agency or therapy company. All fields are required.

Face-to-Face Visit Attestation

I certify that this patient is under my care and that I, or a nurse practitioner/clinical nurse specialist/certified nurse-midwife or physician assistant working in collaboration with me or under my supervision, had a face-to-face visit encounter that meets the physician face-to-face encounter requirements with this patient on:

Date of Visit: / / *mm/dd/yyyy*

Medical Condition

The encounter with the patient was directly related to the **following medical condition**, which is the **primary reason for home health care:**

Clinical Findings In Support of Patient's Eligibility

Provide a summary of **clinical findings that support the patient's eligibility for home health services**, including **specific need for intermittent skilled nursing and/or therapy services.** The Face-to-Face visit findings must be related to the primary reason for home health admission.

Statement of Homebound Status

I certify that the patient's clinical condition, as evidenced in the face-to-face encounter, supports that this **patient is homebound** (i.e., absences from home require considerable and taxing effort and are for medical reasons or religious services OR are infrequent or of short duration when for other reasons) **due to:**

Certifying Physician Name

Physician Phone:

Physician Fax:

Certifying Physician Signature

Date: / /