



**Amistad Homecare Inc.**  
**Home Health Face-to-Face Physician Communication Form**

Office: (210) 474-0037 Fax: (210) 474-0067 Toll Free: 1-877-713-7878 www.amistadhhc.com

**Patient Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_

In accordance with the 2015 Home Health PPS Final Rule: "It is permissible for the Home Health Agency (HHA) to communicate with and provide information to the certifying physician about the patient's homebound status and need for skilled care and for the certifying physician to incorporate this information into his or her medical record for the patient."

**Attestation**

I certify and attest that this patient is under my care and that I – or a nurse practitioner (NP) or physician's assistant (PA) working as an ancillary provider under my supervision – had a face-to-face (F2F) encounter that meets the physician F2F encounter requirements as required by CMS.

**The date this patient was seen/encounter occurred on:** \_\_\_\_\_ **(M/D/Y)**

This patient will be followed by a physician (name): \_\_\_\_\_ (NPI) \_\_\_\_\_  
who will, periodically, review the plan of care. The findings from this F2F communication have been communicated with the patient's community-based physicians who will be assuming this patient's home health plan of care.

\*\*\*Additional Information to Certifying Physician\*\*\* (Both must be filled out completely)

Homebound Status: Patient is confined to home due to difficulty ambulating safely two to three feet, unsteady gate upon ambulating due to bilateral lower extremity swelling/Lymphedema and functional limitations and decreased endurance secondary to inability to ambulate more than five feet. Patient uses a waker to ambulate and maintain steadiness upon ambulating two feet. Requires assistance for all activities due to limited mobility secondary to BLE swelling and shortness of breath with minimal excretion and taxing efferot to leave home. Anthropomorphic restrictions requiring the use of a walker and assistance for safe ambulation.

Medical Necessity for Skilled Care: Patient has diagnosis of Lymphedema/BLE swelling Edema and venous hypertension with inflammation/ open wounds. Patient referred to home health services for Lymphedema treatment and wound care to BLE Patient unable to perform treatments or wound care due to BLE swelling edema/venous hypertense with inflammation and decreased endurance, limited mobility. PT to preform Lympedema treatments and wound care 3x a week for 9 weeks. Skilled nurse to teach on new medication and teaching on signs and symptoms of infection.

"The certifying physician must review and sign off on anything incorporated into his or her medical record for the patient that is used to support his/her certification/re-certification of patient eligibility for the home health benefit."

Based on the above findings, I certify/attest that this patient is confined to the home and needs intermittent skilled nursing care, physical therapy, occupational therapy and/or speech therapy. The patient is under my care and I have initiated the establishment of the plan of care.

Agency Name: Amistad Homecare Inc, NPI 1992791123 Episode start Date: \_\_\_\_\_

Agency Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Printed Name/Credentials:** \_\_\_\_\_