Central Georgia Home Health

Face-to-Face Encounter

Patient Name: _____ Phone Number: (____)_____-_____

Address: _____

DOB: ___/____/____

SS#: ___/____/____

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 requirements with this patient on (insert date encounter occurred)_____/_____/_____

The primary medical reason/condition for the encounter was_____

_____

Further, I certify that my clinical findings support that this patient is homebound as defined in CMS Chapter 7 Medicare Benefits Manual 30.1.1 "The condition of the patient is such that there exists a normal inability to leave home and consequently, leaving home would require a considerable and taxing effort."

Clinical Evidence to support homebound status:_____

_____

The following services are medically necessary for home health care:

☐ Skilled Nursing ☐Physical Therapy ☐Occupational Therapy

☐Speech Therapy ☐ Social Worker ☐HH Aide

Attending MD's name (Print):_____

Resident who performed encounter:_____

Attending Physician Signature: _____Date:____/_____/_____

Thank you for choosing Central Ga Home Health for your patient's home care needs.

Please fax completed form to Central Intake @ 633-4031.