HOMECARE GROUP

tel (866) 323-5974 | fax (866) 571-9636

Face-to-Face Encounter Acknowledgement

Client: ____ DOB: ________________

Diagnoses: ____

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 physician face to face encounter requirements with this patient on:

Date (mm/dd/yy): ______________________

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

☐ **Nursing** ☐ **Physical Therapy** ☐ **Occupational 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**:

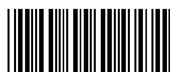
Physician Signature: ____________________________________ Date: ________________

Printed Name: ____

Upon Discharge fax this completed form to 866-571-9636

☐ ________ Initials

17898 REV. 11.2014



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PT.

MR.#/P.M.

DR.