HOME HEALTH ORDER

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FACE-TO-FACE ENCOUNTER

(Please Fax/Attach Patient's History/Physical/Demographics/Insurance ID)

Patient's Name: ______________________

Patient's Address: ______________________

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Phone: ______________________

Date of Birth: ______________________

Sex: ☐ M ☐ F

Medicare #: ______________________

Medical/Insurance #: ______________________

Physician's Name: ______________________

Physician's Address: ______________________

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Phone: ______________________

Fax: ______________________

NPI #: ______________________

Primary Physician: ______________________

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I CERTIFY THAT THIS PATIENT IS UNDER MY CARE AND THAT I, A NURSE PRACTITIONER, OR PHYSICIANS' ASSISTANT WORKING WITH ME, HAD A FACE-TO-FACE ENCOUNTER THAT MEETS THE PHYSICIAN FACE-TO-FACE ENCOUNTER REQUIREMENTS WITH THIS PATIENT ON:

Date: ______________

PRIMARY REASON FOR HOME HEALTH CARE: (MEDICAL CONDITION(S)/DIAGNOSIS)

DIAGNOSIS:	DIAGNOSIS CONTINUED:

I CERTIFY THAT, BASED ON MY FINDING, THE FOLLOWING SERVICES ARE MEDICALLY NECESSARY HOME HEALTH SERVICES:

☐ SKILLED NURSING CARE FOR: ______________________

☐ PHYSICAL THERAPY FOR: ______________________

☐ OCCUPATIONAL THERAPY FOR: ______________________

☐ SPEECH LANGUAGE THERAPY FOR: ______________________

HOMEBOUND STATUS:

I certify that the patient's clinical condition, as evidenced in the face-to-face encounter, supports that this **patient is confined to the home** (i.e., there exists a normal inability to leave home and leaving home requires considerable and taxing effort and is medically contraindicated or requires the assistance of supportive devices, supportive transportation, or another person) due to**: (check all that apply)**

☐ Residual weakness

☐ Requires max assistance/taxing effort to leave home

☐ Severe SOB or SOB upon exertion

☐ Need assistance for all activities

☐ Unable to safely leave home unassisted

☐ Confusion, unsafe to go out of home alone

☐ Other: ______________________

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Physician's Signature: ______________________ **Date:** ______________

(must be signed by MD, DO, DPM or Supervising MD only)