

## Documentation of Face to Face Encounter

Patient Name: \_\_\_\_\_

Patient Identification Number: \_\_\_\_\_

I, Dr. \_\_\_\_\_ certify that the above named patient is under my care and that I, or the nurse practitioner or physician's assistant working with me, had the required face-to-face encounter meeting the encounter requirements on the date identified \_\_\_\_\_.

The primary medical reason/diagnosis/condition for the encounter was \_\_\_\_\_

Additional clinical findings that support home health services (medical necessity) include: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- My findings support the fact the 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"

Based on my findings at this encounter, I certify that the following services are required:

_____ Skilled Nursing	Visit frequency/duration _____
_____ Physical Therapy	Visit frequency/duration _____
_____ Speech/Language Pathology	Visit frequency/duration _____

Physician Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

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

