

# Physician Face to Face Encounter

**Patient Name & Date of Birth:**

\_\_\_\_\_

Name

\_\_\_\_\_

Date of Birth

**Date of Face-to-Face Encounter:** 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 encounter requirements with this patient on \_\_\_\_\_  
(Insert date that visit occurred):

**Medical Condition:** The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care  
(list medical condition): \_\_\_\_\_

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

\_\_\_\_\_ Nursing

\_\_\_\_\_ Occupational Therapy

\_\_\_\_\_ Physical therapy

\_\_\_\_\_ Home Health Aide

\_\_\_\_\_ Speech language pathology

\_\_\_\_\_ Other

**Clinical Findings:** My clinical findings support the need for the above services because: \_\_\_\_\_

**Homebound Status:** 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)

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."

**Physician's Signature:** \_\_\_\_\_

**Date of Signature:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Physician Printed Name:** \_\_\_\_\_