MJHS HOME CARE

Face-to-Face Encounter Certification

Fax: (718) 921-8415/8405

PATIENT INFORMATION

Name _____ Date of Birth ___ / ___ / ____ All scripts # _____

ENCOUNTER INFORMATION

Encounter was performed by a:

☐ Medicare-enrolled (or Medicare opted-out) Physician ☐ Non-Physician Practitioner*

Name _____ Encounter Date ___ / ___ / ____

The patient was referred to home health care do to following medical condition(s)

1. _____
2. _____
3. _____
4. _____
5. _____

The following clinical findings support that the patient is homebound

1. _____
2. _____
3. _____
4. _____
5. _____

Based on the above findings, the following medical home health services are required:

☐ Skilled nursing care for _____

☐ Physical therapy for _____

☐ Occupational Therapy for _____

☐ Speech/Language Therapy for _____

I hereby certify that I have that I am qualified and have privileges to perform a face to face encounter with the above mentioned patient.

Physician's Signature _____ Print Name _____ Date ___ / ___ / ____

*A Face-to-Face may be ***performed by*** a nurse practitioner, clinical nurse, a certified nurse midwife or a physician assistant under the supervision of the physician. However, the only person that can **sign** the actual form is the PHYSIAN.

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