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JCAHO Accredited
Medicare/Medicaid Certified
Licensed, Bonded & Insured

Face to Face Encounter

Patient's Name: _____ DOB: _____

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 _____.

The encounter with the patient was in whole, or in part, for the following medical condition, which is the PRIMARY REASON for home health.

(List primary diagnosis/condition) _____

I certify that, based on my findings, the following services are medically necessary home health services.

(Check all that apply.)

Primary Home Health Services:

Skilled Nursing

Physical Therapy

Speech Therapy

My clinical findings support the need for the above services because:

Further, I certify that my 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 of short duration when for other reasons) because:

I will be transitioning the patient's care to his/her Primary Care Physician:

Dr. _____

Physician's Printed Name: _____

Physician's Signature: _____

Date of Signature: _____

Please fax immediately to Advance Care at 804-897-9058.

www.advancercarellc.com