

## Physician Certification of Need and Orders for Home Health Services

Patient Name: _____ Last Name First Name		Physician Ordering Home Health Services:	
Date of Birth: _____ Sex: F or M		Doctor Name: _____	
Address for Care: _____		Phone: _____ Fax: _____	
Ph: _____ Alt Ph: _____		NPI#: _____	
Caregiver Name: _____ Ph: _____		Patient's Insurance: _____	
Primary Problem for Home Health Care: _____		Insurance Number: _____	
Additional diagnoses: _____			
<b>Services Ordered:</b>			
The following services are medically necessary within 48 hours:			
<input type="checkbox"/> Skilled Nurse <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Speech Therapist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Social Worker			
<b>ATTESTATION OF FACE TO FACE ENCOUNTER</b>			
Encounter Date: _____			
My clinical findings support the need for home health services as follows: _____			
_____			
_____			
I certify my clinical findings support that this patient is homebound per CMS guidelines due to:			
_____			
_____			
(include physical conditions, mental impairments, physician-ordered restrictions)			
I certify that this patient is under my care and that I had a face-to-face encounter that meets the Physician face-to-face requirements with this patient as noted above.			
Signature of Physician: _____		Signature Date: _____	

### IF NO FACE TO FACE ENCOUNTER WITHIN THE LAST 90 DAYS

Scheduled Encounter Date: \_\_\_\_\_ Must be within 30 days of Start of Care  
Physician who will perform (or have NPP perform) the Face to Face encounter and oversee the Plan of Care:

Doctor Name: \_\_\_\_\_