Skilled Care Referral and Documentation of Face-to-Face Encounter

Patient Name	Patient Sex M/F	Patient DOB	Patient Address
Patient Phone #	Responsible Relative or Friend Name		Phone # Relationship
Primary Insurance Number	Secondary Insurance Number	Notes	

Please fax the completed form and include the following information:
- A progress note or a visit note from the clinical encounter dated in section 1 below (Face-to-Face).
- A list of patient's relevant medical history (i.e. problem list).
- Current patient demographics and medication list.
- Any other pertinent medical records.

1. Certification and Date of Face-to-Face Encounter
I certify/re-certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care, and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred _____ **(Date of Encounter)**, or will occur, within time frame requirements and it is related to the primary reason the patient requires home health services.

2. Medical Condition Related to Skilled Care Services
The encounter with the patient was in whole, or in part, for the following medical condition(s), which is the primary reason for skilled care. **(list medical conditions):**

_____
_____
_____
_____

3. Additional clinical findings that support the medical necessity: You may include additional clinical findings to support the skilled services needed:

_____
_____
_____

4. Certification of Medical Necessity and services ordered: I certify that, based on my clinical findings, the following services are medically necessary skilled care services:

☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy
☐ Speech Language Therapy ☐ Home Health Aide Services ☐ Medical Social Work

5. Certification of Homebound Status: My clinical findings from this encounter support the patient is homebound. I certify that this patient meets homebound status.

Patient is confined because of illness, needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

Patient has a normal inability to leave home.

AND

Leaving home requires a considerable and taxing effort for the patient.

Physician Signature: _____ **Date of Signature:** _____ **Time of Signature:** _____ **AM/PM**

Physician Printed Name: _____ **Physician's Phone Number:** _____

Please fax this form and items included in Section 1 to 833-728-0411.

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