



CARE AMERICA HOME HEALTHCARE

OFFICE: (407)464-0194

TOLL FREE FAX: (866)654-8241

NAME: _____ PHONE: _____

ADDRESS: _____

DOB: _____ SSN: _____

PAYER: MEDICARE INSURANCE (COMPANY) _____

MEDICARE ID/ POLICY# _____ GROUP # _____

DIAGNOSIS: _____

DATE OF REFERRAL: _____ START OF CARE: _____

___ RN EVALUATION AND SET UP HOME HEALTH CARE: **PT** **OT** **ST** **HHA** **MSW**

ORDERS: _____

DOCUMENTATION OF FACE-TO-FACE ENCOUNTER FOR MEDICARE PATIENTS

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): _____ (MM/DD/YY)

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 Physical Therapy Speech Language Pathology

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) **because:** _____

MD NAME: _____ OFFICE PHONE: _____

MD SIGNATURE: _____ DATE: _____