Bluebonnet Home Health and Hospice

VERIFICATION DOCUMENTATION
OF FACE-TO-FACE ENCOUNTER

_____

PATIENT NAME AND IDENTIFICATION

Certification Date

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):

_____

MONTH DAY YEAR

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):

_____

_____

Services Needed

I certify that, based on my findings, the following services are medically necessary home health services (*check all that apply*):☐ Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Language Pathology
To provide the following care/treatments: (**Required only when the physician completing the face to face encounter documentation is different than the physician completing the plan of care**):

_____

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:

☐ Residual Weakness ☐ Unable to leave home Unassisted ☐ Medical Restriction
☐ Dependent on adaptive devices ☐ Unable to ambulate without assistive device
☐ Other_____

Certification

Physician Signature: _____Date of Signature: _____

Physician Printed Name: _____