***Physician’s Name***

**Patient:**

**Birth date:**

**Home Health Face-to-Face Encounter Requirement**

**I certify that this patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB\_\_\_\_\_\_\_\_\_\_\_, 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 CMS requirements for this encounter (90 days prior to the start of care date or within 30 days after the start of care date). This face-to-face encounter for this patient occurred on:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Month/Day/Year**

**I certify, based on my findings, that the following services are medically necessary for home health services (check all that apply):**

**\_\_\_ Nursing \_\_ Physical Therapy \_\_ Occupational Therapy \_\_Speech Language Pathology**

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

**I certify that my clinical findings support that this patient is homebound because:**

**Physician Signature Date**