One On One
MEDICAL CARE

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PHYSICIANS CERTIFICATION OF FACE-TO-FACE ENCOUNTER WITH PATIENT

MR # _____

Patient's Name: _____ D.O.B.: _____

Home Health: _____ D.O.S. : _____

- I certifiy that this patient is under my care. I have established a plan of care, and it will be reviewed by a physician periodically, and I or an allowed non-physician practitioner working in collaboration with me had a face-to-face encounter with this patient on: _____
- The encounter with this patient was in whole, or in part, for the following medical condition, whish is the primary reason for home health care:
  LIST OF MEDICAL CONDITION: _____ _____ _____
  _____ _____ _____ _____
- I certify, that basec on my findings, the following services are medically necessary home health services:
  _____ SKILLED NURSING SERVICES _____PHYSICAL THERAPY ____ SPEECH LANGUAGE PATHOLOGY ____ Other
- In addition to the above qualifying service(s), the patient needs:
  _____ Ocupational Therapy _____Social Worker _____ Home Health Aide _____ Other _____
- To provide the following care/treatments *(This is only required when physician completing the face-to-face encounter documentation is different from the physician completing the plan of care)*: _____
  _____
  _____
- Further, I certify that my clinical findings support that this patient is homebound (i.e. obsences from home require considerable and taxing effort, and for medical reasons or religious services, or infrequently, or of short duration when for other reasons) because: (Please check what is applicable)

_____ Needs assistance for all activities
_____ Requires assistance to ambulate
_____ Unable to safely leave home unassisted
_____ Dependent upon adaptive device(s)
_____ Residual weaknes
_____ Confusion, unable to go out of home alone
_____ Severe SOB, SOB upon exertion
_____ Other(s): _____
_____ Medical Restriction

PROVIDER/PHYSICIAN's NAME: _____ , M.D. or D.O.

PROVIDER/PHYSICIAN's SIGNATURE: _____ DATE: _____

COMPLETED BY: _____ _____ DATE: _____
(NP or PA NAME) (NP or PA SIGNATURE)

/AMGI Forma2016-08