ASTERCARE HOME HEALTH LLC

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Face to Face Documentation

☒Patient Information☒

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Other Number: _____

DOB: _____ Medicare #: _____ Sex: ( ) Male ( ) Female

Home Health Face-to-Face Encounter Certification

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 physician face-to-face requirements.

☒Face-to-Face Encounter Date: _____

☒This encounter with the patient was necessitated by the following medical condition(s), which is the primary reason for home health care (*list medical conditions related to need for home health care*):

_____

_____

☒Based on the above findings, the following are medically-necessary home health service(s) (Check ALL that apply):

[ ] Skilled Nursing
[ ] Medical Social Worker
[ ] Physical Therapist
[ ] Speech Therapist
[ ] Occupational Therapy
[ ] Home Health Aide

☒ *Further, I certify my clinical findings support that this patient is homebound due to:*

[ ] Unable to leave home without maximum assistance and/or effort
[ ] Poor ambulation, history of falls
[ ] Unable to ambulate
[ ] Unsteady gait with assistive device
[ ] Difficult and taxing effort to leave home
[ ] Post-operative weakness or complications
[ ] Requires the assistance of 1-2 people to ambulate
[ ] Severe shortness of breath

I certify that the above patient is under my care, requires the above home health service (s), and is confined to his/her home. Further, I certify that this patient is homebound per Medicare's homebound criteria, i.e. there is a normal inability to leave home and requires a considerable and taxing effort. These professional services are to be provided on an intermittent basis and I will review the established plan at least every two months. These services are related to the diagnosis stated above and/or conditions for which he/she received treatment while recently hospitalized.

Physician Name: _____ Physician NPI: _____

Address: _____

Phone: _____ Fax: _____

☒Physician Signature: _____ ☒ Date: _____