

UPMC/Jefferson Regional Home Health
Fax #: 412-578-9681

North Branch South Branch
 Horizon Branch Ohio Subunit

Visiting Nurses Association of Venango
Fax #: 814-432-6588

Home Health Physician Documentation of Face-to-Face Encounter

Patient Name: _____ DOB: _____

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

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):**

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

My clinical findings support the need for the above services because (i.e.: skilled assessment, teaching, wound care, medication management, rehabilitation):

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:

Physician Signature _____

Date of Signature _____

Physician Printed Name _____

FOR OFFICE USE ONLY

Admission #: _____

Document #: _____