1st American Choice Home Health Care Services LLC

- **FACE- TO- FACE- ENCOUNTER / VERBAL ORDER of MEDICARE HOME HEALTH PATIENTS**

AGENCY NAME:_____

PATIENT'S NAME:_____ **DOB:**_____ **HIC:**_____

Date of Face-To-Face Encounter

I certify that this patient is under my care and that I, or a nurse practitioner of 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 _____(date).**

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary care for home health

care_____

Medical Necessity

I certify that based on my finding, the following intermittent skill services are medically necessary home health service (**check all that apply):**

__**NURSING**	____**Speech Therapy**	___**Occupational Therapy**
__**PHYSICAL THERAPY**	____**LMSW**	___**Provider Services**

Clinical Findings

My Clinical findings support the need for the above

because:_____.

MONITOR/ TEACH B/P AND BS IF APPLICABLE

Homebound Status

Further, I certify that my clinical findings support that this patient is homebound (ie Absences from home require considerable effort and are for medical reasons or religious services or infrequently and of short duration when for other reasons)

CIRCLE ALL THAT APPLIES:

DM, DM1, DM2, HTN, HLD, CP, PALPITATIONS, CVD, PVD, HX CVA, ANEMIA, COPD, ASTHMA, SOB, SIMUSITIS, WHEEZING, VISION IMPAIRMENT, ALLERGIC RHIMITIS, GLAUCOMA, ABDOMINAL PAIN, GERD, CONSTIPATION, BACK PAIN, NECK PAIN, MUSCLE SPASM, COUGH, FEVER, ARTHRITIS, OA/DJD, PERIPHERAL NEUROPATHY, GEN WEAKNESS, OSTEOPOROSIS, OBESITY, MORBID OBESITY, OVERWEIGHT, CHF, HX OF MI, CAD, GOUT, SLE, HIV, DEPRESSION, ANXIETY, TOBACCO ABUSE, ETOH ABUSE, CHRONIC PAIN SYNDROME, NONCOMPLIANCE, HYPOTHROIDISM, HYPERTHYROIDISM, SCHIZPHRENIA, BIPOLAR, CARDICA MURMOR, TACHYCARDIA, BRADYCARDIA, ARRHYTHMIA, SKIN RASH, ONYCHOMYCOSIS, TINE CAPITIS, JOCK ITCH, ACNE, DEMENTIA, HERPES SUMPLEX, DIARRHEA, HEARING LOSS, UTI, DYSURIA, NOCTURIA, HEMSTURIA, HEMATOCHEZIA, HEMOPLYSIS, VAGINITIS, & VULVOVAGINITIS, UNBALANCED GAIT, BRONCHITIS, BPH, DVT, DIZZINESS, SEZIURES, HX SYNCOPE, SYNCOPE

PHYSICIAN SIGNATURE (ATTENDING)_____**NPI #**_____

PHYSICIAN ADDRESS_____

AND PHONE NUMBER AND FAX NUMBER_____

PHYSICIAN NAME :_____**Date:**_____

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